D.A.P. Progress Note Checklist

Data	**Check if addressed**
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
3. What was the general content and process of the session?	
4. Was homework reviewed (if any)?	
Assessment	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What are the results of any testing, screening, assessments?	
8. What is the client's current response to the treatment plan?	
Plan	
9. Based on client's response to the treatment plan, what needs revision?	
10. What goals, objectives were addressed this session?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist	
13. Does this note connect to the client's individualized treatment plan?	
14. Is this note dated, signed, and legible?	
15. Is the client name and identifier included on each page?	
16. Has referral information been documented?	
17. Are client strengths/limitations in achieving goals noted and considered?	
18. Are any abbreviations used standardized and consistent?	
19. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
20. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	