



## VA Blue Button: Exploring Your Mental Health Notes

### Mental Health Clinical Note Examples

Mental health clinical notes are notes that clinicians and other health care team members write that summarize information about your health. Your mental health clinician writes a mental health note during or after each appointment with you.

The structure and content of mental health clinical notes can vary depending on your clinician, the type of care you receive, and the purpose of your appointment. Mental health notes frequently include a diagnosis, a summary of what you shared with your clinician, medication updates, your clinician's assessment of your health, a treatment plan or next steps, and other information from your appointment.

On the following pages, you will see examples of three different mental health notes written by three different mental health clinicians: **a psychiatrist, a psychologist, and a social worker.**

Below is an example of a mental health note written by a psychiatrist.

**Date/Time:** 19 Apr 2015 @ 1112

**Note Title:** MHD – INDIVIDUAL NOTE

**Location:** PORTLAND, OREGON VA MEDICAL CENTER

**Signed By:** SMITH,SANDRA

**Co-signed By:** SMITH,SANDRA

**Date/Time Signed:** 19 Apr 2015 @ 1202

#### Note

LOCAL TITLE: MHD - INDIVIDUAL NOTE

STANDARD TITLE: MENTAL HEALTH OUTPATIENT NOTE

DATE OF NOTE: APR 19, 2015@12:02      ENTRY DATE: APR 19, 2015@12:02:30

AUTHOR: SMITH, SANDRA R      EXP COSIGNER:

Primary Diagnosis for this visit: (Diagnosis based on DSM-5 not DSM-IV codes) PTSD

Procedure performed: Psychotherapy and Medications

Length of time with patient during this visit in minutes: 25

IDENTIFYING INFORMATION: CARL THOMAS is a 63 year old MALE with diagnoses of DM II, COPD, lung nodule being followed, PTSD, major depressive episode chronic, recurrent, alcohol abuse in remission, and smoking in remission.

VA ELIGIBILITY: SERVICE CONNECTED 50%.

Veteran and I reviewed/discussed his current psychiatric medications. Inactive or unused medications have been removed or discontinued.

CURRENT STATUS: Veteran doing OK overall. Gets short of breath when walks, but not worse than baseline—does note more pain in legs when walks. Overall coping reasonably. Continues to have persistent dysthymic sx, and we discussed trial of bupropion added to regimen—he is open to this but wants to consider and we agreed to discuss more specifically next visit. No drinking, no increase in depressive sx. Anxiety sx at baseline. No SI. Generally getting enough sleep and says appetite/wt stable—has been able to keep weight off with the walking. Brother coming to visit next month, which is generally stressful, and we explored coping options which have worked for him in the past.

KEY ASPECTS OF MENTAL STATUS EXAM: No sig changes. Grooming somewhat poor today. But affect not restricted--talkative. No attentional or sig memory problems noted.

Active Outpatient Medications (including Supplies):

ALBUTEROL INHALER

CITALOPRAM 20MG TAKE 1 TABLET BY MOUTH DAILY

SIMVASTATIN 40MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME TO LOWER YOUR CHOLESTEROL. AVOID CONSUMING GRAPEFRUIT PRODUCTS.

MOST RECENT VITAL SIGNS: BP:121/63 (12/20/2014 13:15)

PULSE:68 (12/20/2014 13:15); WEIGHT:197 lb [89.4 kg] (12/20/2014 13:15)

ASSESSMENT: Overall stable. Veteran continuing to be physically active which is helping with wt management and probably mood.

RECOMMENDATIONS/PLAN:

1. RTC me in 2-3 months. Veteran has been provided interim contact information including information about the Veteran's Crisis Line.
2. No med changes overall. At next visit, discuss and probably trial bupropion. Need to explore for sz hx.
3. Encouraged ongoing abstinence from alcohol and cigarettes.
4. Encouraged continuing walking at least 20 minutes every day as possible.
5. Encouraged he contact PCP to follow-up on leg pain issues.

/es/ SANDRA R SMITH MD

STAFF PSYCHIATRIST

Signed: 04/19/2015 12:02

Below is an example of a mental health note written by a psychologist.

**Date/Time:** 12 Jan 2016 @ 0915

**Note Title:** MHD – INDIVIDUAL NOTE

**Location:** PORTLAND, OREGON VA MEDICAL CENTER

**Signed By:** KOHLBERG, ELLIOT

**Co-signed By:** KOHLBERG, ELLIOT

**Date/Time Signed:** 12 Jan 2016 @ 1047

**Note**

LOCAL TITLE: MHD - INDIVIDUAL NOTE

STANDARD TITLE: MENTAL HEALTH OUTPATIENT NOTE

DATE OF NOTE: Jan 12, 2016@10:47      ENTRY DATE: Jan 12, 2016@10:47:39

AUTHOR: KOHLBERG, ELLIOT N      EXP COSIGNER:

URGENCY:      STATUS: COMPLETED

Primary Diagnosis for this visit: PTSD

Procedure performed: Psychotherapy

Length of time with patient during this visit in minutes: 60

S/O: Purpose of session is to continue process of identifying treatment goals and plan. This has been difficult due to Veteran's travel schedule, depression and avoidant coping behavior. Mrs. Danielson stated she has thought a lot about what she would like to be in therapy for but stated she couldn't really come up with anything. Upon further discussion, she stated "I want a sense of normalcy."

Session focused on MI to identify daily areas of struggle and the costs related to these. She was able to identify sleep as a main concern as well as 'not fitting in', referring to her difficulty integrating back into her family and civilian life after the military. Mrs. Danielson discussed a long history of feeling apathetic, neglected and 'thrown away' as a child, with similar feelings of late. She stated she did not feel these so strongly in the military. We discussed resiliency factors and sources of support related to the military. Also identified patterns of difficulty identifying needs and communicating them to others which often leave her feeling numb, apathetic, defeated.

Will begin with working on sleep difficulties and continue behavioral activation with building insight into trauma history. Mrs. Danielson cannot participate in CBT-I due to travel schedule.

A:

PTSD, combat related

MDD, recurrent, moderate (per chart)

HTN

GERD

Chronic pain (R shoulder, back, knees)

No evidence of SI/HI

The following plan was made in collaboration with Veteran:

- meet weekly for individual PTSD treatment focused on psychoeducation and skill building
- reduce isolation
- reengage in meaningful activities
- possibility of behavioral activation in future

RTC: 1 week

/es/ ELLIOT N KOHLBERG PSYD

STAFF PSYCHOLOGIST

Signed: 01/12/2016 10:47

Below is an example of a mental health note written by a social worker.

**Date/Time:** 26 Feb 2016 @ 1128

**Note Title:** MHD – INDIVIDUAL NOTE

**Location:** PORTLAND, OREGON VA MEDICAL CENTER

**Signed By:** TU, IRENE

**Co-signed By:** TU, IRENE

**Date/Time Signed:** 26 Feb 2016 @ 1241

**Note**

LOCAL TITLE: MHD - INDIVIDUAL NOTE

STANDARD TITLE: MENTAL HEALTH OUTPATIENT NOTE

DATE OF NOTE: FEB 26, 2016@12:41      ENTRY DATE: FEB 26, 2016@12:41:07

AUTHOR: TU, IRENE K.      EXP COSIGNER:

URGENCY:      STATUS: COMPLETED

Primary Diagnosis for this visit(ICD-10 code not required):

(Diagnosis based on DSM-5 not DSM-IV codes) Major Depression Disorder

Procedure performed: Psychotherapy only

Length of time with patient during this visit in minutes: 60

S&O: Purpose of the session was individual therapy focusing on self-esteem and developing emotional awareness. Writer also discussed with Veteran her planning for future group treatment. Writer provided Veteran with information on emotional intelligence, including two exercises she can use to increase emotional awareness, one piece on emotional intelligence. Writer explored self-esteem with Veteran, particularly her sense of self-esteem across different situations and in different relationships.

Veteran expressed excitement about continuing group treatment with rehabilitation program, and discussed the groups she plans to join for mental and physical health. She reports that she continues to spend time with a new friend. She reports that her self-esteem is good in these situations, that it is mainly diminished around women, but that it is better when she is talking to a woman with her friends around.

Appearance: Appropriately dressed and groomed

Physical Activity: Normal

Mood: Euthymic

Affect: Appropriate

Engagement: Easy

Rapport: Easy

Eye contact: Good

Social Maturity: Developmentally appropriate

Awareness of social cues: (X)Good ( )Poor

Attention/Concentration: Alert, focused

Speech: Normal

Language: Normal

Interest: High

Cooperation: Full

Pace: Appropriate

A: Ms. Smith is a 40 year old single Veteran who presents with depression, low self-esteem, and social isolation. She is currently unemployed and recently moved into stable housing. Veteran has a history of substance abuse but reports abstinence of over 10 years.

P: Continue weekly therapy sessions. Next session continue focus on self-esteem. Veteran to continue attending groups offered by the VA. Goals endorsed by veteran: improve self- esteem, increase relationship skills, reduce depression.

/es/ IRENE K. TU MSW

CLINICAL SOCIAL WORKER

Signed: 02/26/2016 12:41