

## DOCUMENTATION AID

## Psychiatric progress note structure

An educational outline for structuring an outpatient psychiatric follow-up note. A documentation aid, not a template for any specific case.

**Educational example only.** This is not legal, medical, or compliance advice, and it is not a ready-to-use legal document. Requirements vary by state, payer, and setting. Adapt anything like this to your own situation and have it reviewed by qualified legal and compliance counsel licensed in your jurisdiction before using it in a practice. You are responsible for compliance with all applicable federal and state laws, including HIPAA. shrinkiatry publishes professional commentary and education, not legal or medical advice.

*Current as of July 7, 2026. Laws, payer rules, and billing codes change. Confirm the current requirements for your jurisdiction and setting before you rely on anything here.*

### Subjective and interval history

What has changed since the last visit: symptoms, function, sleep, side effects, adherence, stressors, and the patient's own report.

### Objective and mental status

A mental status exam appropriate to the visit. See the mental status exam quick reference.

### Assessment

- Working diagnosis and clinical impression
- Risk assessment, including any safety screen and the reasoning
- Response to treatment

### Plan

- Medication decisions and the reasoning, plus monitoring
- Therapy, referrals, and coordination
- Follow-up interval and safety plan if relevant
- Time and coding note if coding by time

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