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.

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

shrinkiatry is the profession layer of The Shrink Network. Reviewed by Shariq Refai, MD, MBA, FAPA, a board-certified psychiatrist. More educational resources at shrinkiatry.com/resources/.