DAP note template

Blank template. Replace each [prompt] with session details.

SESSION HEADER

```
Client: [name or ID]            DOB: [date]
Date of service: [YYYY-MM-DD]   Start-stop: [00:00-00:00] ([n] min)
Service: [individual / family / group / case management]
Setting: [in person / telehealth: platform, audio+video, consent on file,
          client location, clinician location]
Participants: [client only / client + name, relationship]
Diagnosis being treated: [code, description]
Treatment plan goal addressed: [goal]
```

DATA

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Client report and quotes: [what the client said, in their words]
Observations: [appearance, behavior, affect, speech, thought process]
Measures: [instrument = score, date; prior score, date]
Risk screen: [SI / HI / self-harm: questions asked and answers]
Interventions delivered: [methods used in this session]
Collateral / required reports: [who, when, why, consent]
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ASSESSMENT

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Progress toward goal: [improved / unchanged / worse, and the evidence]
Measure interpretation: [severity band and change]
Risk formulation: [risk factors, protective factors, risk level]
Functional impact: [work, school, relationships, self-care]
Need for continued care: [why this level and frequency are indicated]
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PLAN

```
Next session: [date, time, frequency]
Interventions and target: [method; measurable goal and date]
Homework: [specific tasks the client agreed to]
Safety steps: [plan reviewed or updated, resources given]
Coordination / referrals: [who, why, consent on file]

Signature: [name, credentials]   Signed: [YYYY-MM-DD 00:00]
```

DAP note example (fictional)

Filled example from the guide: adult client, routine individual therapy session.

Client: [ID] Date of service: 2026-11-02
Session: 10:00-10:53 (53 min), individual psychotherapy, in person
Clinician: [Name, credentials]

DATA

Client stated, "I've been in bed most of the weekend and I called in sick on Monday." Reports sleeping 4-5 hours a night for the past week and skipping meals. Arrived on time, casually dressed, hygiene fair. Affect flat, speech slow and soft, eye contact intermittent. Thought process logical and goal-directed. PHQ-9 completed today = 17 (12 on 2026-10-19). Risk screen: denied suicidal ideation, intent or plan; denied homicidal ideation. Completed 1 of 3 planned activities from last session. Intervention: behavioral activation review and activity scheduling; cognitive restructuring of "I can't do anything right."

ASSESSMENT

Depressive symptoms have worsened since last session. PHQ-9 rose from 12 (moderate) to 17 (moderately severe), consistent with reported anhedonia, sleep loss and missed work. Low completion of planned activities suggests the current activity targets are too large. Client engaged in restructuring and generated one alternative thought. No current suicide risk indicators; protective factors include a supportive sister and continued engagement in treatment. Continued weekly therapy is indicated by the symptom increase and impaired occupational functioning.

PLAN

1. Continue weekly individual therapy; next session 2026-11-09 10:00.
2. Behavioral activation: client agreed to 2 activities of 15 minutes each (walk, call sister) before next session and to log completion.
3. Sleep: keep a sleep log; review sleep routine next session.
4. Repeat PHQ-9 next session. If the score rises again or SI emerges, review the safety plan and discuss a psychiatric medication evaluation with the client.
5. With client consent on file, send a coordination note to the PCP about the score increase this week.

Signed: [Name, credentials] 2026-11-02 14:10