

Sample Progress Note for Suicide Risk

Annotations have been included in italics to help you understand the structure of the note. This note is for a client who has moderate suicide risk and will be treated as an outpatient. Moderate risk clients need very careful documentation because risk is significantly elevated, yet the psychotherapist must justify why outpatient treatment is appropriate.

S/O. Ms June Yee is a 42 year old single Asian female who works as an administrative assistant. She lives by herself in a condo. She said that her mother died one month ago, very suddenly from a heart attack. She stated that she and her mother were very close—they talked by phone daily and spent time together at least once a week.

[This first paragraph is a brief orientation to Ms Yee's life situation.]

Ms Y reports a history of chronic depression with poor self-esteem, feelings of guilt and chronic sadness. She reported that this has worsened within the past month since her mother died. Now she has difficulty falling asleep because she is ruminating about losing her mother. She feels tired and has had little appetite. She says that she cries every day. She has lost about 10 lbs without trying and is markedly thin.

[This second paragraph is a description of her depressive symptoms. Note that the paragraph begins with a topic sentence. A different paragraph should be started for each type of symptoms, e.g. depressive, anxious, psychosomatic and so on.]

Although she states that she “just doesn’t want to go on,” Ms Y has been continuing to go to work. However, she says that she has been having difficulty concentrating and getting her work done. She said that she missed 2 days of work last week because she was feeling too bad to go in.

[This paragraph describes her recent difficulties with work functioning that are related to her depression and grief.]

She denied any suicide plans. However, she states that she sometimes thinks that “it would be better if I were dead.” She denied any suicidal intent or behavior now or in the past. Ms Y stated that she sometimes feels hopeless. She denied having any family members who have committed suicide. She indicated that she has been thinking of cutting herself lately, but that she hasn’t done that since she was 22 years old. She said that she used to cut herself superficially with a razor on “too many occasions to count” when she was upset, but that this was a way of coping with distressing feelings and she did not intend to kill herself. She denies any violent thoughts or any history of violent behavior.

[The above paragraph describes Ms Y's suicide risk factors in detail and makes it clear that the psychotherapist has screened for violence risk.]

Ms Y stated that she was sexually abused as a child. She has had nightmares about twice a week for years, but since her mother's death they have become more frequent. Ms Y stated that she drinks three to four glasses of wine by herself every night. She has some insight that this is problematic.

[The above paragraph briefly mentions a history of child sexual abuse, although the interviewer did not completely assess PTSD or trauma in this intake session. Problematic alcohol use is noted.]

Ms Y. said that she attends her church on a weekly basis. She volunteered that she and her church consider suicide to be a sin. She has several close female friends, but she has been avoiding them. She said that she is very close to her sister and her niece, and she knows that if she committed suicide this would devastate them.

[The above paragraph includes important information about protective factors.]

Ms Y readily agreed to call 911 or go to her nearest emergency room if she feels that she is at risk of enacting self-harm or a suicide attempt.

[If you are treating someone as an outpatient, you must discuss this with a client who has a strong wish for death or has suicidal ideation, and you must include a sentence like this one.]

A. Diagnostic Impression: Major depression, alcohol abuse.

Ms Y's warning signs for suicide are as follows: thoughts of wishing for death last week—although she denied having any today, occasional feelings of hopelessness, insomnia, current thoughts of cutting—although no action on that, sudden recent loss with intense grief.

Ms Y's suicide risk factors are as follows: history of childhood sexual abuse, chronic depression, history of cutting, alcohol abuse, may have PTSD as well.

Ms Y's suicide protective factors are as follows: Asian-American ethnicity, age, no history of suicide attempts, denies current and past suicidal intent, denies suicide plan, feels suicide is a sin, knows suicide would devastate sister and niece, close relationships with friends, sister and niece.

[Above is a recap of warning signs, risk factors and protective factors from the Subjective/Objective portion of the note.]

Suicide Risk level: Moderate risk. She does not have any history of suicidal behavior and denies any current suicidal intent. However, I have elevated her risk level to moderate because she has some history of self-harm, even without suicidal intent, and has recently been thinking of cutting again. In addition, she has been emotionally unstable lately with feelings of hopelessness. Her functioning level has decreased recently—she called in sick for 2 days last week because of depression. It is likely that she has been chronically depressed, which is recently worsened by the sudden loss of her mother—one of her most important social supports. In addition, she is drinking too much, adding to the risk of impulsive behavior, and may have PTSD as well. I expect that her risk level can rapidly be reduced to low with more intensive interventions for the first few weeks of treatment.

[Note the thorough discussion of the clinician's assessment of suicide risk above.]

Ms Y denied any current or past violent ideation or behavior, so my assessment is that she has no violence risk.

I did not further evaluate her history of sexual abuse, because gathering further information in this area can be destabilizing. So this is deferred until she is more emotionally stable.

P. I talked with Ms Y about the importance of ongoing treatment for depression. She stated that she understood. She accepted an appointment tomorrow with a psychiatrist for medication evaluation. I have scheduled twice weekly sessions with her during the first few weeks of treatment. Her next session is in 2 days. Also, I will check in with her by phone tomorrow. I obtained an intake appointment for the partial hospitalization program for tomorrow as well.

I asked Ms Y to make plans to see her sister, her niece and at least one of her close friends over the next week. She agreed to do so.

I gave her a note to give to her Human Resources department at work so that she can attend intensive treatment for at least 2 weeks.

I suggested that she attend alcohol treatment, but at this time, she stated that she wanted to try to cut down on alcohol use on her own. There are dual diagnosis groups in the partial hospitalization program that she can be assigned to. I will assess her PTSD symptoms soon, as tolerated.

[The psychotherapist clearly describes the exact details of the initial plan for treatment and follow-up in the Plan portion of the note, above. Emphasis is placed on timely and intensive treatment of her acute distress. Note that re-engagement with social supports is emphasized as well.]

/signed/

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/cosigned/

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