DAP Note Cheat Sheet

DAP Notes are a simpler form of note taking for behavioral health professionals. The difference between the SOAP and the DAP format is that the Data section contains all data regarding the session without separating it into subjective and objective segments. The Assessment and Plan sections are the same. ICANotes has compiled this DAP Note Cheat Sheet as a checklist for behavioral health providers to use when writing notes in the DAP format.

D – DATA (or description of the problem) – answers the question "What did I see?" Document everything the clinician observes and hears during the session.	**✓ if addressed**
Subjective data – the client's observations, thoughts, and direct quotes	❑
Objective data – what the clinician observes during the session (including mental status exam)	❑
Document outcomes of assessments/rating scales and test results (e.g., labs or vital signs)	❑
Describe the client's presenting problem or reason for the session	❑
Document the client's reporting of existing symptoms or critical events since the last session	❑
Was any homework reviewed?	❑
What was the general content and process of the session?	❑
Describe any interventions using during the session and the client's response to those interventions	❑
A – ASSESSMENT– answers the question "What does it mean to me?" This section describes the clinician's interpretation of the session.	**✓ if addressed**
The clinician's assessment of the problem and the client's diagnosis (or changes to the diagnosis)	❑
Identification of therapeutic goals, targets, and desired outcomes (including any changes to goals)	❑
What is the client's current response to the course of treatment / treatment plan?	❑
Evaluation of self-harm	❑
Evaluation of suicidal thoughts	❑
Evaluation of homicidal thoughts	❑
P – PLAN – answers the question "What am I going to do about it?" Document any actionable steps the client or the clinician will take and strategies for future treatment.	**✓ if addressed**
Client homework and/or takeaways for the client to reflect on	❑
Referrals to other organizations/professionals	❑
Recommendations	❑
Patient education	❑
Monitoring plan and follow-up	❑
Date and time of next session	❑
General Note Checklist	**✓ if addressed**
Does this note link to the client's individual treatment plan?	❑
Is the note dated and signed?	❑
Is the client's name and identifier included on each page of the note?	❑
Are the client's strengths/limitations in achieving goals noted?	❑
Would someone unfamiliar with the case be able to review the note and understand what occurred during treatment?	❑

Write Better DAP Notes with ICANotes

ICANotes offers clinically robust note templates with automatic formatting and coding that help behavioral health professionals significantly improve their note-writing and documentation time. If you want to learn more about how our software can benefit your practice, **request a free trial** to get started. The sample note below was written in ICANotes.

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Mathison, Carrie

11/2/2023
4:44:14 PM

ID: 1000010685701 DOB: 7/25/1985

Progress Note

DATA

Ms. Mathison was on time for today's session. She continues to describe depressive-related symptoms. She reports no changes to her energy level. Today it is reported that the loss of pleasure has lessened in frequency or intensity. Her sadness has also lessened in frequency or intensity. Sleep issues continue to occur. She says "I'm still finding it difficult to get motivated to leave my house, but my focus at work has improved."

Ms. Mathison appears flat, casually groomed, and relaxed. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Signs of mild depression are present. She appears listless and anergic. Thought content is depressed. Body posture and attitude convey an underlying depressed mood. Speech and thinking appear slowed by depressed mood. Ms. Mathison's affect is flat. Associations are intact. There were no signs of psychotic symptoms this session. Ms. Mathison's cognitive functioning was not formally tested today but appears clinically to be unchanged from previous examinations. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Ms. Mathison's behavior in the session was cooperative and attentive with no gross behavioral abnormalities. Ms. Mathison was administered the PHQ-9 depression assessment test. She scored between 10-14, indicating that a Moderate Depression is present. Her exact score is 10.

Medication has been taken regularly. Self-care skills are intact and unimpaired. Her domestic skills are intact. She is socializing less with family and friends. Ms. Mathison is performing normally at work. She has difficulty falling asleep.

Ms. Mathison today discussed her problems with friendships. She also discussed her depressed mood and her issues of low self-esteem and her pattern of self-defeating behavior.

ASSESSMENT

Ms. Mathison today exhibits a partial treatment response. Ms. Mathison was an active participant in today's session. She was able to recognize her progress and explore her challenges openly in this session. A goal of the session was to improve Ms. Mathison's ability to express emotions and to improve her self-esteem. The sources of her feelings were explored using open-ended questions, reflection, and rephrasing. Today, to enhance her self-esteem, Ms. Mathison was given positive feedback and unconditional positive regard. She was counseled and educated regarding the risks and benefits of treatment.

Mathison, Carrie

ID: 1000010685701 DOB: 7/25/1985

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4:44 PM

Progress Note

In assessing the risk of suicide or violence, it was noted that Ms. Mathison is experiencing rapid shifts in mood, which is a current risk factor. However, she has protective factors, such as the presence of beloved pets. During the suicide risk assessment, Ms. Mathison acknowledged having suicidal thoughts but denied any intentions or plans to act on these thoughts. Consequently, based on these observations and factors, her risk of suicide is categorized as low. She may have fleeting suicidal thoughts, but there is no evident intention or plan behind them.

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Major depressive disorder, recurrent, moderate, F33.1 (ICD-10) (Active)

PLAN

Client will continue medication as prescribed by psychiatrist and report any side effects immediately. The next session is scheduled for Wednesday, March 10 at 2 pm. Assigned the client a thought record chart to specifically log instances of automatic negative thoughts regarding relationships. Client to follow steps of established safety plan if symptoms significantly worsen prior to the next scheduled session. No changes indicated to the treatment plan.

90837 Psychotherapy 60 min.

Sandy Demo, LPC

Electronically Signed By:
Sandy Demo, LPC
On: 11/2/2023 4:45:48 PM