Clinical record

Client | Date | Session no.

1. Client profile and referral source

Name, contact, date of birth, who referred the client.

2. Assessment and formulation

Presenting concerns, history, risk, your working formulation.

3. Treatment plan and informed consent

Goals, approach, frequency, fees; consent given and how.

4. Progress notes

Date, what was addressed, interventions, the client's response.

5. Consultations and correspondence

Supervision, contact with other providers, letters, with the client's consent.

6. Closing summary

When and why services ended, outcome, recommendations.

> A working template, **not an official CRPO form.** Check the current Professional Practice Standards. Records are kept for at least 10 years after the last interaction with the client.

Clinical record: filled example

Client Anna, 34 (fictional) | Date 11/12 | Session no. 4

1. Client profile and referral source

Anna, 34, analyst. **Self-referred** after a colleague's recommendation.

2. Assessment and formulation

Work-related anxiety since March, short sleep. **Checking keeps the anxiety going.** No risk identified.

3. Treatment plan and informed consent

Reduce checking, sleep 7 hours. Weekly CBT. **Consent discussed and signed** at intake, including limits of confidentiality.

4. Progress notes

Session 4: reviewed thought records, **"They'll fire me for a single mistake"** twice. Agreed to check the report once.

5. Consultations and correspondence

Discussed in clinical supervision on 11/05, no identifying details.

6. Closing summary

Not yet, **services ongoing**.

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