

Write a Clinically Useful Note

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Support accurate notes that connect the session to care without inventing observations.

A useful clinical note explains what occurred, why the work was relevant, and what happens next. Follow the actual documentation requirements of your setting and payer where applicable. This handout is a writing aid, not a legal or billing standard.

Distinguish information types

Attribute client and collateral reports. Describe relevant observations precisely. Mark clinical interpretations as interpretations, and state important uncertainty. Do not convert an unasked question into a denial or a copied template phrase into an observed fact.

Connect intervention and response

Identify what you actually did and its connection to the treatment goal. Describe the client's response using meaningful behavior or their account. "Practiced one request and revised it after feedback" is more informative than a list of modalities without a documented activity.

Document decisions and follow-up

Record significant changes, indicated assessment, consultation, referrals, and the agreed plan. If risk was assessed, document the relevant findings and actions through your clinical process; a single generic phrase is not a substitute.

Use only necessary detail

Include information needed for continuity and accountability. Avoid unnecessary intimate narrative, speculation, stigmatizing labels, or claims of progress unsupported by the session. Review the note for internal consistency before signing.

One documentation habit I will change