De-identified Clinical Assessment + Treatment Plan + Progress Note

Student: Brooke Holloway
Site: Compassion House (Field Placement)
Competency: 7 – Assess Individuals, Families, Groups, Organizations, and Communities
Practice Behavior 7.1: Formulate comprehensive assessments using a variety of diagnostic classification systems
Confidentiality Statement: This document contains **de-identified** examples created for educational/portfolio purposes. It includes **no names, initials, DOB, addresses, schools, case numbers, or identifying details**.

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1) Comprehensive Clinical Assessment Summary (De-identified)

Client ID: Client A (Adolescent)
Date/Time of Assessment: Friday, April 11, 2025 | 3:00–3:55 PM
Service Type: Individual Therapy – Intake/Assessment

Presenting Concerns

Client A presented with persistent anxiety symptoms, sleep disruption, frequent self-blame thoughts, and difficulty regulating emotions when triggered by stressors. Client reported avoidance of certain topics due to distress and described feeling "on edge" most days.

Relevant History (Biopsychosocial)

Biological: sleep disruption, fatigue, reported somatic anxiety symptoms (restlessness, muscle tension).
Psychological: excessive worry, rumination, negative self-talk/self-blame, emotional dysregulation when triggered.
Social/Family: conflict and stress within the family system; limited perceived support at times; caregiver stress reported.
Environmental: ongoing stressors and instability contributing to heightened anxiety and reduced coping capacity.

Screening Tools Used (Evidence-Based)

GAD-7 (Anxiety): 16 (moderately severe)
PHQ-9 (Depression): 12 (moderate)

Risk Assessment (Brief)

Client **denied** current suicidal ideation, intent, or plan. Client **denied** self-harm intent. Protective factors included active engagement in services, identified supportive adult(s), and willingness to practice coping strategies. Plan included routine check-ins for safety and coping support.

DSM-5-TR Diagnostic Impression (Provisional)

Primary: Generalized Anxiety Disorder (F41.1) – provisional, based on persistent worry, sleep disturbance, irritability/tension, and functional impact.
Secondary/Monitoring: Other Specified Depressive Disorder (F32.8) vs. Depressive symptoms related to stressors (monitoring recommended due to PHQ-9 score and clinical presentation).
Clinical Note: Diagnostic impression was reviewed as *provisional* pending continued observation, collateral context as appropriate, and symptom tracking over time.

Initial Clinical Formulation

Client A's anxiety symptoms appeared maintained by a cycle of worry → physiological arousal → avoidance → short-term relief → increased long-term anxiety. Negative self-beliefs ("I'm the problem") contributed to emotional distress and reduced coping confidence. A CBT-informed approach with trauma-informed engagement strategies was selected to support stabilization, skill-building, and gradual reduction in avoidance.

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2) Treatment Plan (De-identified)

Client ID: Client A
Plan Date: Friday, April 11, 2025
Frequency: Weekly sessions (45–60 minutes)
Primary Approach: CBT-informed, trauma-informed engagement; skill-building and cognitive restructuring; symptom monitoring

Goal 1: Reduce anxiety severity and improve emotional regulation

Baseline: GAD-7 = 16; client reported frequent worry and difficulty calming body response.
Objectives:

- Client practiced at least **2 coping skills** (grounding, breathing, relaxation) at least **4 days/week**.
- Client reduced anxiety intensity from average **8/10 to 5/10** over 6–8 weeks (self-report).
  Interventions:

- Psychoeducation on anxiety cycle and stress response
- Skill practice in session (diaphragmatic breathing, 5–4–3–2–1 grounding)
- Coping plan for triggers (step-by-step)
- Progress monitoring (weekly anxiety rating + brief check-in)

Goal 2: Decrease self-blame thoughts and increase balanced thinking

Baseline: frequent automatic thoughts ("everything is my fault").
Objectives:

- Client identified **1 automatic thought per session** and labeled the distortion when applicable.
- Client generated **1 balanced replacement statement** per session and practiced between sessions.
  Interventions:
- CBT thought-feeling-behavior triangle
- Thought log (simplified)
- Cognitive restructuring practice (challenge/replace statements)
- Strengths-based reframing and validation

Goal 3: Improve sleep routine and daily functioning

Baseline: sleep disruption and fatigue reported.
Objectives:

- Client increased nights with adequate sleep from **2 to 4 nights/week** over 6–8 weeks (self-report).
- Client identified **two** evening coping strategies to support wind-down.
  Interventions:
- Sleep hygiene education (routine, screen limits, calming activities)
- Evening coping plan
- Track sleep patterns weekly and adjust strategies as needed

Plan Review Date: May 23, 2025 (or earlier if symptoms worsen)

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3) Progress Note Example (De-identified)

Client ID: Client A
Date/Time: Friday, April 25, 2025 | 3:00–3:45 PM
Service Type: Individual Therapy
Focus: Anxiety coping skills + CBT thought work

D (Data)

Client reported anxiety spikes during the week and difficulty sleeping on two nights. Client completed a simplified thought log for one situation and identified an automatic thought related to self-blame. Client practiced grounding (5–4–3–2–1) in session and reported feeling "more settled" afterward.

A (Assessment)

Client demonstrated increased insight into the thought-feeling-behavior cycle and participated actively in skill practice. Anxiety remained elevated but client showed improved willingness to use coping strategies rather than avoidance.

P (Plan)

Continue weekly sessions. Practice grounding once daily and use breathing strategy when triggered. Complete one thought log entry before next session. Continue monitoring sleep and anxiety intensity ratings.