My Healio

for the days you feel too much

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Therapy Session Recording Form
(Name of the Institute/Hospital/Centre with address)

Clinic record no._____

THERAPIST SESSION NOTES

Patient name:
Age:
Session number & date:
Gender:
Duration of session:
Psychiatric diagnosis:
Session Participants:

Therapy method:

- **Individual**

Objectives of the session:

1.
2.
3.
4.

Key issues/themes discussed: (Psychosocial stressors/Interpersonal problems/Intrapsychic conflicts/Crisis situations/Conduct difficulties/Behavioural difficulties/ Emotional difficulties/ Developmental difficulties/ Adjustment issues/ Addictive behaviours/Others)

Therapy techniques used:

Therapist observations and reflections:

Plan for next session:

Therapist
Name
Date
Qualification
RCI Registration Number
Signature

Supervised by (if applicable)
Name
Date
Qualification
RCI Registration Number
Signature