**DAP  
 (Data, Assessment, Plan)**

Here is a note for our hypothetical client, Maya. We'll look at each section separately to see what things we can take out.

**First, let's check out the Data section:**

**Long Version:** Client arrived five minutes late to session. She looked really stressed and was in her workout clothes. I offered her water and had her sit down. Reminded her of the mindfulness exercises we reviewed last week and asked how she did with practicing them over the last week. She talked about difficulty concentrating and about how her son kept interrupting her so he could get help with homework. She asked her mother to help him but she was busy as well. Client spent much of the session making excuses for why she probably won’t be able to implement the exercises at home. She then started talking about wanting to go on a “girls’ retreat” for the weekend with some friends and how it’s the only thing that helps her feel better these days. She was reluctant to leave the session at the end and said, “This is so helpful. Thank you for being here for me. I don’t know what I’d do without this.” Then left immediately.

You may notice a LOT of extraneous information. There are also lots of details that aren't necessary. This is just a matter of sticking to the most important facts and taking out our really specific language. Here is how we can make this note a bit better (and shorter):  
  
**Short Version:**Client arrived late and appeared flustered. Reported feeling stressed and having difficulty implementing mindfulness based exercises previously reviewed in sessions. I assisted her in practicing the techniques and problem-solving ways to implement at home.

See? The details about difficulty making a decision on whether or not to attend a girls' retreat and exactly how she attempted the mindfulness exercises are irrelevant. We still get a good sense of how she is progressing and what happened during the session without having a total play-by-play.  
  
**Now, let's look at the Assessment section:**  
  
**Long Version:** The client seems resistant to implementing practices discussed in session and continues to be stuck in a recurring cycle of promoting her anxiety. She appears to prefer excuses to trying to work on her goals. She continues to use her son as an excuse so she does not have to focus on her own needs or working through her own issues with guilt and anxiety. However, also presents as somewhat codependent, declaring how helpful therapy is even though she doesn’t follow through.  
  
Okay, for this section we have some quality concerns... namely, the very subjective language. How do you think Maya would feel if she read that? Probably not great. I'm not saying our goal with notes is to appease our clients, but we should be respectful and as objective as possible, even during a more interpretive section like the Assessment.   
  
So how could we word this differently and also make this shorter? Let's see:  
  
**Short Version:**Client is having difficulty managing her needs with family demands. Remains committed to therapy.  
  
Did that just blow your mind right now? It's so short! But really, considering this session, there's not much more we need. We already discussed her difficulty implementing techniques in the Data section and there's no need to harp on that point.

Instead, we focus on what all the stuff in the Data section means as far as what we really need to be working on. We also kept things very objective hile adding something positive about her treatment thus far.   
  
**Okay, now let's look at the final section, the Plan:**  
  
**Long Version:** Client will try using meditation and journaling again over the next week. She will update me on her progress with mother and son. We’ll meet again on 06/02/XX.  
  
This section is pretty easy to keep short, regardless, so I didn't make as much of a change here. But I did take out the extraneous information and simplify things...   
  
**Short Version:**Client will practice exercises reviewed in session. Next session is 06/02/XX.

And there you have it... a great, simple note! I want to summarize a few pointers based on the differences between these long and short versions:

* Remove extraneous information that's irrelevant to treatment or progress.
* Remove the “gory” details and use more general language.
* Keep the general focus of the session as the focus of the note (without letting other things distract you!).
* Leave out subjective language and consider how your client would feel reading the note
* Leave in client quotes if they're relevant. They often say more than any interpretation you could create.

If you liked this breakdown of how to simplify your notes, you may also want to check out my upcoming trainings and my [paperwork packet](https://app.ruzuku.com/courses/15117/about). I not only offer forms (which includes four different note templates) but also spell out directions for how to implement them.

I love doing this stuff and if it helps you, everybody wins!