SAFETY = Safety/risk factors
Have I documented the safety and/or risk factors?

F Functional impairment
How does the individual’s condition or situation impact his/her/their ability to function in important domains, like work, school, home, etc.?

I Interventions
What important treatment interventions did I use, and what was the clinical reasoning behind them?

R Response
How did the client respond to me or to my treatment interventions? How did he/she/they present?

S Symptoms
What symptoms came up? Document both the symptoms you observe in session (tearfulness, physical agitation, etc.), and the reported symptoms (insomnia, lack of appetite, etc.), as well as the Mental Status Exam.

T Therapeutic Interpretation
What do I think about this client and their care when I factor in all of the information above (safety/risk concerns, functional impairment, interventions, response, symptoms)? This could include the following:

- Treatment compliance/lack of compliance
- DSM-V diagnosis
- Clinical impressions regarding diagnosis and/or symptoms
- Progress and/or lack of progress toward treatment plan goals
- Relapse potential and/or risk factors for relapse
- Prognosis
- Information reflecting the clinician’s exercise of clinical judgment
- Plan for the next session (ie- what methods will be used, other providers that will be contacted and why, etc.)