**Where Does it Hurt?  The Importance of Documenting Impairment**

*By Barbara Griswold, LMFT (July, 2019)*

     The progress notes you write after an Intake interview or therapy session have to cover a host of topics, including the client’s presenting problems, their symptoms, their response to treatment, and your interventions.  But one of the most important questions therapists frequently overlook in documentation is how is the client’s life being impaired by their mental health symptoms?

This may seem obvious, but identifying and documenting impairment isn’t always easy, especially when a client or couple is high functioning.

    Why is documenting impairment critical?  It is an essential part of making the case that therapy is “medically necessary,” which is key to insurance coverage for therapy.  And whether insurance is involved or not, documenting why treatment is needed and a client’s progress toward better functioning at the heart of any professional medical record.  It can also help a client win a disability leave or worker’s compensation case.

How does one go about documenting impairment?  It starts with asking the right questions — conducting a thorough initial assessment, and repeatedly checking in with the client throughout treatment about their impairment status.

Here are some areas that should be assessed and documented:

**Work**:  Has the client been coming late, leaving early, missing days or taking days off? Having difficulty focusing?  Is work performance, quality, or speed suffering?  Are there any tasks client hasn’t been able to do due to symptoms? Have emotions been erupting at work (e.g. crying, or snapping at coworkers)?  Have coworkers noticed behavior change, or is the client’s job in jeopardy? Does the client have difficulty getting along with coworkers, or keeping jobs?

**Academic:**  Has school attendance, performance, quality of work, or grades been affected?  Has the client been able to finish assignments?  Has anyone at school noticed a change in the client’s behavior?  Has there been any inappropriate behavior or emotions in the classroom?

**Self-Care/Activities of Daily Living (ADLs):** Is the client eating skipping meals, binging, or eating in an unhealthy manner?  Has there been weight loss or gain, or a change in frequency of getting out of bed, taking a shower, and getting dressed?  Has the client stopped wearing makeup or brushing his/her hair? Has the client stopped doing other usual self-care rituals (ex. exercise, therapy, meditation)?

**Life Tasks/Activities of Daily Living (ADLs):**  Have symptoms affected the client’s ability to pay bills and manage finances?  To drive or take transportation? To maintain a home (e.g. cleaning, laundry, dishes, shopping, and meal preparation)?  Is the client hoarding/cluttering?  Is the client managing mail, phone and email?  Is the client managing medications, both obtaining them and taking as directed?

**Primary relationships:**  Have relationships with parents, children, and partners been affected?  Is the client more irritable/impatient with them?  Is the client escaping into a computer screen or retreating to a bedroom instead of engaging with family?  Is the client unable to perform usual responsibilities around the house, so others must take these on?

**Interpersonal:**  Have friendships been affected?  Has the client become withdrawn, or more dependent?  Does the client have few friends, perhaps due to mental health issues?  Has the client stopped going to usual social, community, or religious activities?

**Health:**  Has health been affected by mental health symptoms (ex. pain, headaches, stomach issues, tension-related body aches)?  Is anxiety or denial causing the client to avoid medical appointments, or to not follow doctors’ recommendations?

**Sleep:**  Has the client’s sleep been impacted?  How many hours of sleep is the client averaging?  Document oversleeping (hypersomnia) as well as difficulties falling asleep and staying asleep, nightmares, waking feeling tired, and daytime drowsiness and fatigue.  How frequently is each a problem?  Is client falling asleep at work?

**Financial:**  Is anxiety or addiction causing self-destructive financial behavior, such as compulsive buying, overspending, or pathological gambling?  Is the client helping others financially when s/he can’t afford to do so?

**Substance use:**  Has there been a change in the client’s use of cigarettes, alcohol, marijuana, or other drugs, perhaps related to mental health issues?  Has the client had any negative consequences related to this use?  Is the client taking prescriptions in any way other than prescribed?  Is anyone worried about the client’s substance use?

**Judgement:**  Is the client demonstrating poor judgements or making impulsive decisions that are leading to negative consequences?

Remember, impairment is not something that is documented only in the intake note — it should be something that is assessed in every session.

Sound like a lot to cover?  Never fear!  With a little practice, you can learn to *quickly*document a bit of impairment in each progress note.

Want to see how?  [Check out my Progress Notes Webinar](http://www.theinsurancemaze.com/store), with progress note samples and downloadable templates.