Mental Health DAP Note Example

Fictional example for reference. This illustrates a progress-note narrative, not a complete clinical record.

Encounter detail	Example
Client	DEMO-01, adult
Date	October 8, 2026
Session	Individual, in person
Time	10:00-10:50, 50 minutes

D: Data

Client reports that she has not told her sister she attends therapy and worries about repeated check-ins. Rehearsing possible conversations has distracted her from evening tasks. The clinician observed clear speech, relevant responses and longer pauses when discussing disclosure.

The clinician explored hoped-for and unwanted outcomes, helped identify a privacy boundary, and rehearsed a possible opening sentence. The client identified what she would keep private and said the exercise clarified that boundary. She remains unsure whether she wants to tell her sister. When asked, the client denied thoughts of harming herself or others.

A: Assessment

Anticipated family reactions appear to contribute to indecision and distraction from evening tasks. The client clarified one privacy boundary during the session and remains undecided about disclosure.

P: Plan

Client and clinician agreed that the client would make a private list of what she would and would not feel comfortable sharing. At the next appointment on October 15, 2026, revisit the decision and its effect on evening activities.

Reviewing the AI draft

In a DAP note, Data combines what the client reported with what the clinician observed. The first AI-generated draft filled both with a conversation that had not happened. The clinician corrected it before saving.

AI draft said	What happened in session
Client reports telling her sister she attends therapy and receiving a supportive response.	Client has not told her sister and remains unsure whether she wants to.
Client appeared relieved when describing the conversation with her sister.	Client paused longer when discussing disclosure. No conversation with her sister has taken place.

Use the structure and level of detail as a reference. Write from the actual encounter and meet the documentation requirements that apply to your practice and payer.