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| **Patient Progress Note Form** | | | | |
| Organization: | | | | |
| Programs or Services: | | | | |
| Interview – Date:  Interview Start Time:  Interview Stop Time: | | Interview Type:  Phone  Face-to-Face (specify location): | | |
| **DEMOGRAPHICS** | | | | |
| Individual Name: | | | Prefers to Be Called: | |
| Primary or Preferred Language:  English  Spanish  Other: | | | | |
| Preferred Method of Communication:  Oral  Written  Sign Language | | | | |
| Date of Birth: | | | Country of Birth: | |
| Birth Gender:  Male  Female  Gender Orientation:  Male  Female | | | Race/Ethnicity: | |
| **CLINICAL/CASE MANAGEMENT** | | | | |
| Clinical/Case Record: | | | Plan for Care, Treatment, or Services – Date: | |
| Authorized Staff: | | | | |
| Admission or Entry – Date: | | | | |
| Reason for Care, Treatment, or Services: | | | | |
| **SESSION PARTICIPANTS** | | | | |
| Individual  Family/Guardian  Significant Other(s)  Licensed Mental Health Counselor (LMHC)  Licensed Practitioner of the Healing Arts (LPHA)  Licensed Mental Health Professional (LMHP)  Psychiatrist  Physician  Social Worker  Case Manager  Other Providers: | | | | |
| ***Session Purpose*** | | | | | |
| Individual’s Purpose for Session: | | | | | |
| Notes on Purpose for Session: | | | | | |
| ***Progress Status*** | | | | | |
| Active issues since last session: | | | | | |
| Change in active issues since last session: | | | | | |
| Related interventions (per Clinical/Case Plan):  *Meetings*  AA  Al-Anon  EA  NA  OA/ABA  SMA  SLAA  Obtain Sponsor  Contact Sponsor – Times per Week:  Attend Multifamily Group | | | | | |
| Proposed changes to plan: | | | | | |
| ***Discharge Status*** | | | | | |
| **Criteria 1:** | Defined – Date:  Projected – Date:  Achieved – Date: | | | |
| **Criteria 2:** | Defined – Date:  Projected – Date:  Achieved – Date: | | | |
| **Recommendations for Continuity of Care, Treatment, or Services:** | Defined – Date:  Projected – Date:  Achieved – Date: | | | |
| ***Rationale for Continuing Current Care, Treatment, or Services*** | | | | | |
| This individual would be at high risk for the following if discharged prior to the projected date:  As evidenced by status below. | | | | | |
| ***Mental Status*** | | | | |
| ***Speech***  Normal  Delayed  Loud  Pressured  Slurred  Soft  Other: | | | | |
| ***Cognition/Attention***  No Deficits  Impaired Level of Consciousness  Preoccupied  Distracted  Focused  Other: | | | | |
| ***Attitude***  Cooperative  Suspicious  Seductive  Hostile  Negative  Uncooperative  Indifferent  Evasive  Demanding  Passive  Positive  Receptive  Other: | | | | |
| ***Mood***  Euthymic  Dysphoric  Euphoric  Other: | | | | |
| ***Affect***  Normal  Restricted  Blunted  Flat  Inappropriate  Labile  Other: | | | | |
| ***Thought Content***  Normal  Magical Thinking  Persecution  Dissociation  Phobias  Obsessions/Compulsions  Hopelessness  Worthlessness  Helplessness  Excessive Guilt  Other: | | | | |
| ***Thought Process***  Goal-Directed/Linear  Tangential  Flight of Ideas  Loosened Associations  Incoherent  Thought Blocking  Other: | | | | |
| ***Insight***  Good  Fair  Poor | | | ***Judgement***  Good  Fair  Poor | |
| ***Orientation***  Person  Place  Time/Date  Situation | | | | |
| ***Delusions***  Yes  None If Yes, describe: | | | | |
| ***Hallucinations***  Visual  Auditory  Tactile  Olfactory  None | | | | |
| ***Intelligence***  Above Average  Average  Below Average | | | | |
| ***Memory*** *Immediate:*  Intact  Impaired *Recent*:  Intact  Impaired  *Remote:*  Intact  Impaired | | | | |
| ***Self-Destructive Behaviors***  Risk-Taking (specify):  Self-Mutilation (specify):  Other: | | | | |
| ***Suicidal***  Yes  No If Yes, conduct a Suicide Risk Assessment and attach. | | | | |
| ***Violent/Homicidal***  Yes  No If Yes, describe: | | | | |
| ***Miscellaneous***  Chills  Cravings  Headaches  Low Energy  Sensitivity to Light  Sweats  Nausea  Tearful  Other: | | | | |
| **Weight**  Decrease  No change  Increase  Refused | | | | |
| Plan for Care, Treatment, or Services updated, per above changes | | | | | |
| **ATTESTATION** | | | | | |
| Individual Signature: | | | | Date: |
| Family/Guardian/Significant Other(s) Signature:  N/A | | | | Date: |
| Counselor Signature: | | | | Date: |
| QMHP/Supervisor Signature: | | | | Date: |
| LPHA/Physician Signature: | | | | Date: |