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| **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:  |