Patient Progress Notes

Patient Name: ______________________________ ID# ______________ Date: _________________

Current Symptoms:

___ Poor sleep	___ Irritability	___ Inferiority feelings	___ Blurred vision
___ Poor appetite	___ Personality changes	___ Hearing voices	___ Tremulousness
___ Increased appetite	___ Constipation	___ Seeing things	___ Avoiding people
___ Weakness	___ Diarrhea	___ Anger	___ Inability to have fun
___ Decreased sex drive	___ Weight loss	___ Fearfulness	___ Irritability
___ Hyperventilation	___ Suspiciousness	___ Phobias	___ Excessive worrying
___ Palpitations	___ Fearfulness	___ Social withdrawal	___ Tension numbness
___ Depression	___ Lack of interest	___ Dry mouth	___ Sexual problems
___ Headaches	___ Feelings of guilt	___ Nightmares	___ Nausea
___ Cries easily	___ Family problems	___ Dizziness	
___ Indecisiveness	___ Tinnitus	___ Tachycardia	
___ Work problems	___ Physical complaints	___ Suicidal ideation	

Other ____

____

Current Medications:

Medication Dosage How Taken Date Started/Stopped

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Medication Changes: ___________________________________ Side Effects: _________________

Mental Status:

Orientation: Person ___ Place ___ Time ___ Situation ___________________________

Speech: Lucid ___ Fragmented ___ Disorganized ___ Blunted ___ Mute ___

Mood: Appropriate ___ Inappropriate ___ Depressed ___ Anxious ___ Angry ___ Flat ___
Apathetic ___ Labile ___ Constricted ___ Other ___________________________

Thought Process: Coherent ___ Goal directed ___ Rational ___ Loose ___ Other ___

Thought Content: Relevant ___ Expansive ___ Grandiose ___ Suicidal ___ Homicidal ___
Cognitive distortions ___ Auditory hallucinations ___ Other ___

Assessment: (Clinical response, functional impairments, justification for continued treatment):

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Informed Consent Updates and Releases Signed, Explanations Given:

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Current Treatment Plan:

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Therapist Signature ______________________________ Next Appointment _________________