Psychiatric Progress Notes

PATIENT'S NAME:		DATE:	

CURRENT SYMPTOMS: *Please fill in ALL that is located above the mid-page line. Thank you!*

PLEASE READ EACH SYMPTOM AND RATE ITS IMPACT:
0 = none
1 = mild (impacts quality of life but not significant on functioning)
2 = moderate (significantly impact on quality of live and functioning)
3= severe (profound impact on quality of life and on day to day functioning)

Depressed Mood	0 1 2 3	Alcohol Abuse	0 1 2 3	Sexual Dysfunction	0 1 2 3
Appetite Disturbance	0 1 2 3	Drug use	0 1 2 3	Impaired Memory	0 1 2 3
Sleep Disturbance	0 1 2 3	Generalized Anxiety	0 1 2 3	Delusions	0 1 2 3
Elimination Problem	0 1 2 3	Panic Attacks	0 1 2 3	Hallucinations	0 1 2 3
Low Energy	0 1 2 3	Phobias	0 1 2 3	Impaired Judgment	0 1 2 3
No Motivation	0 1 2 3	Obsessions/Compulsions	0 1 2 3	Physical Complaints	0 1 2 3
Poor Concentration	0 1 2 3	Homicidal Ideas	0 1 2 3		
Agitation	0 1 2 3	Irritability/Anger	0 1 2 3		
Suicidal Intent/Plan	0 1 2 3	Paranoid Ideas	0 1 2 3		
Suicidal Thoughts	0 1 2 3	Binging/Purging	0 1 2 3		

Overall, severity of all your physical and mental condition put together? 0 1 2 3

Overall compared to last visit? Same Better Worse

Rating of Ability to Do Things, in 3 areas, compared to an Average Person

	Poorest				Average					Best
Self-care	1	2	3	4	5	6	7	8	9	10
Relationships	1	2	3	4	5	6	7	8	9	10
Education/Occupation	1	2	3	4	5	6	7	8	9	10

Current Medications (which you are taking daily now)

Medication	Strength	Frequency	Date begun?	Was the most recent change… Good?	Bad?	No Difference
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____

Significant Side Effects that you do not like from the medicine: _____

_____

Rx. Adherence: 0% 25% 50% 75% 100 %

I concur with the patient's above assessments, except where I've annotated.

REPORT OF NEUROBEHAVIORAL EXAM:

Speech: W.N.L. Or:_____	Loose Associations	0 1 2 3	Tense/restless	0 1 2 3	Alertness	0 1 2 3
Gait W.N.L. or:_____	Circumstan./Tangential	0 1 2 3	Guarded	0 1 2 3	Inattention	0 1 2 3
Posture W.N.L. or _____	Abnormal movements	0 1 2 3	Depressed	0 1 2 3	Impaired Knowledge	0 1 2 3
Oriented: Time, Place, Person	_____of 3 words remembered after 5 min		Problem Naming	0 1 2 3	Impaired Judgment	0 1 2 3
Serial 7 subtr.:____ correct			Problem Planning	0 1 2 3	Impaired Insight	0 1 2 3

ASSESSMENT: Dx: _____ : _____ + others indicated in the initial workup.

Prognosis (Risk of Morbidity): ☐ high ☐ moderate ☐ low

OVERALL SEVERITY GAF Score____

☐ Progress ☐ Same ☐ Regression

INTERVENTIONS: (see separate order sheets for details of the next 3 items):

☐ MEDICATION: ___anti-anxiety ___anti-depressant ___antipark ____mood stabilizer ___neuroleptic ___ stimulant

☐ MAINTAIN: (☐ since refuses changes)

☐ TESTS: (LAB) (PSYCH)

☐ CONSULT WITH _____

☐ HOMEWORK ASSIGNED: _____ ☐ Obtain extra psychotherapy with_____ ☐ Full informed consent given.

- Medical Psychotherapy/Counseling regarding: □ suggestions made for change □ resistance to change
- Pertinent Interval History & Themes:
- Support, Guidance, Education, Insight given

GOALS/PLANS: **1. Lower symptoms:** _____ **2. Increase functioning:**_____

Provider Collaboration_____

Start Time: _____**Stop Time:**_____

Follow Up: _____

Billing Code: ☐ **99212** ☐ **99213** ☐ **99214** ☐ **99215**

Missed Appointment Date: _____

_____**of**_____ **Individual Conjoint Family**

Session #

_____**M.D.**

Geoffrey Di Bella, M.D.