

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 life 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		

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	

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

Overall compared to last visit? Same Better Worse

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: _____

Start Time: _____ Stop Time: _____

Billing Code: 99212 99213 99214 99215

Provider Collaboration _____

Follow Up: _____

Missed Appointment Date: _____

_____ of _____ Individual Conjoint Family
 Session #

M.D.

Geoffrey Di Bella, M.D.