

**Harmonious Mind LLC - Adult Pt. Progress Report – Page 1 of 2**

Date	Pt. Name	Pt. DOB	Insurance Co.	Pharmacy Tel
				<b>PROVIDER USE ONLY</b>
Any <b>Health Insurance</b> related changes since your last visit?				
Are you or family member involved in any <b>court case</b> ?				
Describe your <b>sleep</b> ; include if there is trouble falling asleep or waking up a lot at night. Any scary <b>dreams</b> ?				
How is your <b>appetite</b> ?				
Any changes in your <b>weight</b> ?				
How is your <b>energy</b> level?				
How has your <b>mood</b> been?				
Any <b>crying</b> or <b>withdrawing</b> from others?				
Have you had any <b>thoughts</b> of <b>harming yourself</b> ?				
Do you have any <b>plans</b> to <b>harm yourself</b> ?				
Have you <b>tried</b> to <b>harm yourself</b> recently?				
How do you <b>cope</b> with thoughts of <b>hurting</b> / <b>harming</b> yourself?				
Any feelings of <b>hopelessness</b> ?				
Any symptoms of <b>elated mood</b> since the last visit?				
Have you been <b>aggressive</b> : • <b>verbally</b> • physically to <b>people</b> • to <b>property</b>				
Any <b>plan</b> to <b>harm others</b> ?				
Have you thought of <b>running</b> away?				
Any scary or angry <b>inner voices</b> or <b>visions</b> ?				
Any trouble <b>trusting</b> ?				
Any feelings of <b>agitation</b> ?				
Any feelings of <b>paranoia</b> ?				
Sense of being outside or pulled into your body?				
Any <b>panic attacks</b> or anxiety (heart beat fast, stomach churn, marked anxiety or nervousness)?				
Any <b>fear of being out</b> in car, in store, or in presence of others, or in crowds?				

Any urges to <b>steal, gamble, spend, fire-set</b> ?		<b>PROVIDER USE ONLY</b>
Any <b>memory problems</b> ?		
Any <b>confusion spells</b> ?		
Circle & Describe other significant details including: - <b>Medication</b> Changes - <b>Emergency</b> Visit to ER/Doctor - New <b>Stresses</b> - Overall <b>progress</b> or <b>worsening</b> of symptoms - <b>Changes in school, work, home, family, relationships, peer, etc.</b> - General Symptoms - Aches, pain, muscle stiffness, etc. - Eyes - ENT - Cardiovascular – Palpitations, etc - Respiratory - Gastrointestinal - Genitourinary - Muscular - Integumentary - Neurological - Endocrine - Hematologic - Allergies		
Any <b>side-effects</b> from psychiatric medications?		
Are you using <b>alcohol</b> or any illicit <b>drugs</b> ?		
What have you been working with your <b>therapist</b> on?		
Questions you may like to ask the doctor about <b>medicines</b> ?		
Other concerns you may have?		
<p><b>PROVIDER USE ONLY</b> For additional information, see typed note.</p>		
<p><b>Pt. Signature</b> _____ <b>Clinician's Initial</b> _____ <b>Date</b> _____</p>		