Psychiatric Follow-Up Progress Note

Patient Information

Name: _____ Date of Birth: __ Date: _ Appointment Type: ☐ Medication Management ☐ Therapy ☐ Combined ☐ Other: __

Subjective

Presenting Concerns

Symptom Review (check all that apply and circle change)

Symptom	Present	Change	Symptom	Present	Change
Depressed mood	☐	Better/ Same/Worse	Sleep disturbance	☐	Better/ Same/Worse
Anhedonia	☐	Better/ Same/Worse	Appetite changes	☐	Better/ Same/Worse
Energy level	☐	Better/ Same/Worse	Concentration	☐	Better/ Same/Worse
Anxiety	☐	Better/ Same/Worse	Panic attacks	☐	Better/ Same/Worse
Irritability	☐	Better/ Same/Worse	Mood swings	☐	Better/ Same/Worse
Elevated mood	☐	Better/ Same/Worse	Racing thoughts	☐	Better/ Same/Worse
Hallucinations	☐	Better/ Same/Worse	Delusions	☐	Better/ Same/Worse
Obsessions	☐	Better/ Same/Worse	Compulsions	☐	Better/ Same/Worse

Symptom	Present	Change	Symptom	Present	Change
Trauma symptoms	☐	Better/ Same/Worse	Substance use	☐	Better/ Same/Worse
Suicidal ideation	☐	Better/ Same/Worse	Homicidal ideation	☐	Better/ Same/Worse

Medication Review

Current psychiatric medications:

Medication	Dose	Frequency	Adherence	Side Effects	Effectiveness

Medication changes since last visit: ☐ None ☐ Yes (details): _____

Side effects: ☐ None ☐ Yes (details): _____

Medication adherence: ☐ Full ☐ Partial ☐ Poor (details): ___

Psychosocial Update

Recent stressors: _____

Changes in living situation: ☐ None ☐ Yes (details): _____

Changes in relationships: ☐ None ☐ Yes (details): _____

Changes in occupational/educational functioning: ☐ None ☐ Yes (details): _____

Substance use since last visit: ☐ None ☐ Alcohol ☐ Tobacco ☐ Cannabis ☐ Other: _____ **Pattern/frequency:** _____

Objective

Vital Signs

BP: __ HR: _ RR: _ Temp: __ Weight: _ BMI: _ Change from last visit: _____

Rating Scales (if applicable)

PHQ-9 Score: _ Previous: _ Change: _ GAD-7 Score: _ Previous: _ Change: _ YMRS Score: _ Previous: _ Change: __ Other Scale: __ Score: __ Previous: __ Change: _____

Mental Status Examination

Appearance: ☐ Well-groomed ☐ Disheveled ☐ Other: **____ Attitude:** ☐ Cooperative ☐ Guarded ☐ Hostile ☐ Other: **____ Psychomotor activity:** ☐ **Normal** ☐ **Agitated** ☐ **Retarded** ☐ **Other: ___ Speech:** ☐ **Normal rate/volume** ☐ **Pressured** ☐ **Slow** ☐ **Loud** ☐ **Soft** ☐ **Other:** _____

Mood (self-reported): _____ Affect: ☐ **Full range** ☐ **Restricted** ☐ **Blunted** ☐ **Flat** ☐ **Labile** ☐ **Incongruent** ☐ **Anxious** ☐ **Irritable** ☐ **Euphoric** ☐ **Dysphoric** ☐ **Other: __**

Thought process: ☐ Logical ☐ Tangential ☐ Circumstantial ☐ Loose associations ☐ Flight of ideas ☐ Thought blocking ☐ Other: ____

Thought content: ☐ No abnormalities ☐ Delusions ☐ Paranoia ☐ Obsessions ☐ Phobias ☐ Ruminations ☐ Suicidal ideation ☐ Homicidal ideation ☐ Other: **____ Details: _____**

Perceptual disturbances: ☐ None ☐ Hallucinations ☐ Illusions ☐ Depersonalization ☐ Derealization Details: **_____**

Cognition: Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation Attention/Concentration: ☐ Intact ☐ Impaired (details): **____ Memory:** ☐ **Intact** ☐ **Impaired (details): _____**

Insight: ☐ Good ☐ Fair ☐ Limited ☐ Poor ☐ Absent **Judgment:** ☐ Good ☐ Fair ☐ Limited ☐ Poor ☐ Impaired

Risk Assessment

Suicidal ideation: ☐ No ☐ Yes If yes: ☐ Passive ☐ Active Plan: ☐ No ☐ Yes (details): _____ **Intent:** ☐ **No** ☐ **Yes (details):** _____ **Access to means:** ☐ **No** ☐ **Yes (details):** _____ **Protective factors:** _____

Homicidal ideation: ☐ No ☐ Yes If yes: ☐ Passive ☐ Active Plan: ☐ No ☐ Yes (details): _____ **Intent:** ☐ **No** ☐ **Yes (details):** _____ **Access to means:** ☐ **No** ☐ **Yes (details):** _____ **Potential victims:** _____

Self-harm behaviors: ☐ No ☐ Yes (details): _____ **Other risk factors:** _____

Laboratory/Diagnostic Results (if applicable)

Assessment

Current Diagnoses: Primary: _____ **Secondary:** _____

Clinical Status: ☐ Improved ☐ Stable ☐ Worsened ☐ Partial improvement ☐ Mixed response Details: _____

Treatment Response: ☐ Good ☐ Partial ☐ Minimal ☐ None ☐ Worsening Details: _____

Functional Status: ☐ Improved ☐ Stable ☐ Worsened ☐ Partial improvement ☐ Mixed response Details: _____

Plan

Medication Changes

☐ No changes ☐ Increase: _____ ☐ **Decrease:** _____ ☐ Discontinue: _____ ☐ New medication: _____ ☐ **Other:** _____

Psychotherapy/Counseling

☐ Supportive interventions ☐ Cognitive-behavioral techniques ☐ Motivational interviewing ☐ Skills training ☐ Other: _____ **Focus:** _____

Laboratory/Diagnostic Orders

Consultations/Referrals

Safety Plan

☐ No changes to existing plan ☐ New/revised safety plan: _____

Patient Education Provided

Follow-up Plan

Next appointment: __ **Frequency:** __ ☐ Call sooner if: _____ ☐ Other instructions: _____

Provider signature: _____ Date: __ Credentials: _____ License #: _____