Nursing Assessment Progress Note

Community Counseling Services

Rev 01/17

Case Name ____________________

Case Id# ____________________

Date: ____________________

Service Code: ____________________

Start Time: _________ **End Time:** ________ **Minutes** ______

Review of Treatment Status:

Medication Compliance	□ Yes □ No □ N/A	Stabilization of Mood/Depression/Anxiety	□ Yes □ No □ N/A
Medication Stabilized	□ Yes □ No □ N/A	Stabilization of Appetite	□ Yes □ No □ N/A
Sleep Stabilized	□ Yes □ No □ N/A	Stabilization of Psychological Stressors	□ Yes □ No □ N/A
Personal Hygiene Stabilized	□ Yes □ No □ N/A	Comments: ____________________	

Treatment since Last Medication Clinic Visit:

Since you were last seen, have you been to any other doctor? □ Yes □ No □ None Reported ____________________

Recent Hospital/Institution stay? □ Yes □ No If Yes, Date(s) ____________________ Where? ____________________

New or Changes in Medication: □ Yes □ No If Yes, List(&update Med Profile): ____________________

____

Patient Concerns: ____

____

____

Mental Status:

General Appearance	☐Appropriate	☐Unkempt	☐Disheveled	☐Odor	
Eye Contact	☐Good	☐Poor	☐Intermittent	☐Visual Impairment	☐Fair
Behavior/Motor Activity	☐Normal	☐Restless	☐Cooperative	☐Hostile/Aggressive	☐Guarded/Watchful
Orientation	☐Alert &Orientated	☐Coherent	☐Other ____________________		
Speech	☐Appropriate ☐Slurred	☐Hyper-verbal ☐ Impoverished	☐Rapid/Pressured ☐Non-Verbal	☐Soft/Slow ☐Loud	
Memory	☐ Intact	☐Impaired	☐ Other ____________________		
Mood	☐Euthymic ☐Angry/Irritable	☐Depressed ☐Other ____________________	☐Anxious ☐Dysphoric	☐ Labile	
Affect	☐Appropriate	☐Flat	☐Restricted ☐Tearful	☐Anxious ☐Apathy	☐Blunted
Thought Processes /Content	☐Goal Directed ☐Logical ☐A/V Hallucinations	☐Organized ☐Circumstantial -Type:____________________	☐Concrete ☐Distractible ☐FOI ☐Flat	☐Age-Appropriate ☐Poverty of Content ☐None Reported	☐Rambling
Suicidal/Homicidal Risk	☐Denies	☐Current or Recent S/H Ideation(s)/Attemps	☐No Plan	☐No Intent	☐None Reported

Today's Weight: _____________ ☐N/A **Previous Weight** _____________ ☐N/A **Weight Change since last visit(+/-)** ____________☐N/A

Today's Blood Pressure __________/___________ ☐N/A **Previous Blood Pressure** __________/___________ ☐N/A

Today's Height _________ ☐N/A **Today's Pulse** _________ **Time:** ________☐N/A **Today's Respirations:** _______ **Time:** _______ ☐N/A

Does patient smoke? □ Yes □ No If Yes, how many packs per day? ______ Would you like information on how to quit smoking? □ Yes □ No

Information Given:

□ 800-QUITNOW (800) 784-8669

□ http://www.quitlinems.com

□ Quitline Flyer - http://www.quitlinems.com/files/Quitline%20Flier%20Revised%200421101.pdf

□ Information about Chantix http://www.passquiton.com/help-someone-quit-smoking.aspx?cmp=Chantix_Global_CTA

For Insulin Dependent Individuals:

Today's Blood Glucose: _____________ **Have you eaten today?** □ Yes □ No If Yes, t**ime:** ___________

Have you taken your injection today? □ Yes □ No If Yes, how many units**:** ___________

Would you like information about eating healthier to aid in controlling your diabetes? □ Yes □ No

Information Given:

□ http://www.nlm.nih.gov/medlineplus/tutorials/diabetesmealplanning/db059105.pdf
□ http://forecast.diabetes.org/diabetes-101
□ http://www.ndep.nih.gov/media/FS_AfricanAM.pdf?redirect=true

Assessment of Progress:

Other comments:

Medication Side-Effects/Risks/Benefits/Alternative explained? □ Yes □ No □ N/A □ Per Chart

Patient states understanding □ Yes □ No □ N/A

Follow-up Appointment ___ /____/__________

____ ______________________________
Nurse's Signature and Credentials Date

____ ______________________________
Supervisor's Signature and Credentials *(if applicable)* Date