

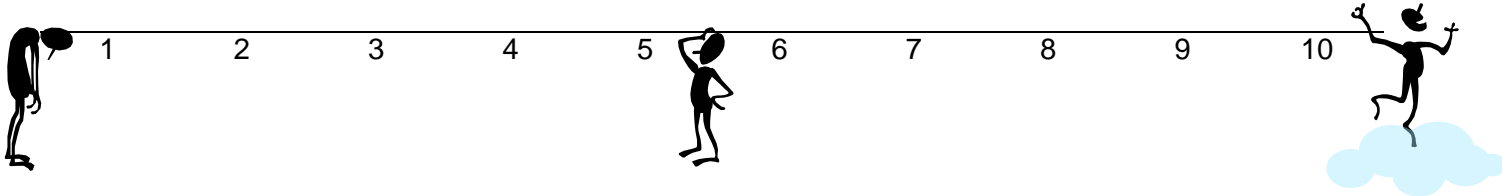
Joint Patient-Therapist Progress Note

Name _____

Date/time _____

Please help both of us to make our next session more productive:

On the **Overall Quality of Life Scale** with 1 being the worst and 10 – the best it could be, I place myself at a:



All in all, compared to my last visit or compared to the same time last year
 I feel much better somewhat better about the same worse not sure

My sleep is: excellent good so-so poor not sure different on different nights
 I average < 6 hours sleep/24 hours I spend > 10 hours in bed/24 hours
 I don't feel refreshed by sleep I often feel sleepy during the day

My concerns to address at this session:

- | | | |
|---|---|---|
| <input type="checkbox"/> Appetite or weight changes | <input type="checkbox"/> Hard to be productive | <input type="checkbox"/> Physical problems |
| <input type="checkbox"/> Can't enjoy things | <input type="checkbox"/> Hearing or seeing things | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Communication problems | <input type="checkbox"/> Medication concerns | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Thoughts about hurting self/others |
| <input type="checkbox"/> Fears of _____ | <input type="checkbox"/> New stressors | <input type="checkbox"/> Tired a lot |
| <input type="checkbox"/> Feeling hyper, nervous, restless | <input type="checkbox"/> Panic (anxiety) attacks | <input type="checkbox"/> Upsetting thoughts or urges |
| | <input type="checkbox"/> Painfully shy | <input type="checkbox"/> Worried about __ |
- Other issues:
 Would you like to elaborate further?

Patient's Signature

Therapist's Signature & Credentials