CrossRoads To Intervention Daily Progress Note

CASE #:__________  CLIENT NAME:__________  DATE:______________
TIME:____________  PLACE:______________  NUMBER IN GROUP:______

SERVICE PROVIDED:
- INDIVIDUAL THERAPY
- CASE MANAGEMENT
- IND. BLS
- GROUP THERAPY
- IND. T:HERAPY
- BEHAVIORAL MAN.
- FAMILY THERAPY
- GROUP BLS
- FAMILY SUPPORT
- Boot Camp
- OTHER

DAY OF WEEK:  MONDAY  TUESDAY  WEDNESDAY  THURSDAY  FRIDAY
NEXT APPOINTMENT:  MONDAY  TUESDAY  WEDNESDAY  THURSDAY  FRIDAY
DATE:______________  TIME:______________

CASE MANAGER NAME:__________________  AGENCY:__________________

MENTAL STATUS: (CHECK WHERE APPLICABLE)

AFFECT:  APPROPRIATE  INAPPROPRIATE
MOOD:  ANXIOUS  DYSPHORIC  euthymic  EXPANSIVE  IRRITABLE

THOUGHTS OR PERCEPTIONAL DISTURBANCES:
- HALLUCINATIONS  DELUSIONS  SUICIDAL  HOMICIDAL  PARANOID  N/A

MEDICATION:
- N/A  COMPLIANT  NON-COMPLIANT

SIDE EFFECTS FROM MEDICATIONS:
- N/A  NO  YES, DESCRIBE

SLEEP:
- GOOD  FAIR  POOR  INSOMNIA  NIGHTMARES  HYPERSOMNIA

APPETITE:
- GOOD  FAIR  POOR  ANOREXIA  BULIMIA

COMMENTS:
__________________________________________________________________________________

GOALS ADDRESSED:
__________________________________________________________________________________

INTERVENTION:
__________________________________________________________________________________

OUTCOME:
__________________________________________________________________________________

CLIENTS SIGNATURE

PROVIDER'S SIGNATURE AND TITLE