Progress Update

For Wm. Bryan Bell,M.D, Theresa Monroe,APRN

Patient's Name: _____ Today's Date: _____

1. List current medication(s) – include all prescribed and over-the-counter medicines

_____ _____ _____

_____ _____ _____

_____ _____ _____

2. Are you experiencing any current side effects problems with your psychiatric medications?
YES NO *If YES please describe.* _____

_____

3. Do you have any problems taking your psychiatric medication(s) as prescribed? YES NO *If YES please explain.* _____

_____

4. Please rate the following symptoms as they apply since your last appointment (circle number):

	Never	Monthly	Weekly	*2-4 Days/Week*	5-7 Days/Week
Difficulty with sleep	0	1	2	3	4
Loss of pleasure in life	0	1	2	3	4
No motivation	0	1	2	3	4
Hopelessness	0	1	2	3	4
Helplessness	0	1	2	3	4
Excessive guilt	0	1	2	3	4
Fatigue	0	1	2	3	4
Excessive energy	0	1	2	3	4
Poor concentration / forgetful	0	1	2	3	4
Poor appetite	0	1	2	3	4
Excessive appetite	0	1	2	3	4
Excessive anger / irritability	0	1	2	3	4
Excessive anxiety	0	1	2	3	4
Thoughts of suicide, homicide (circle)	0	1	2	3	4
Hyperactive	0	1	2	3	4
Defiant	0	1	2	3	4
Paranoia	0	1	2	3	4
Hallucinations	0	1	2	3	4
Compulsive behavior	0	1	2	3	4
Drug and/or alcohol use	0	1	2	3	4

5. Are there any other concerns you would like Dr. Bell or the Nurse Practitioner to discuss with you?

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6. Current therapist's/counselor's name: _____

(*Please return this form to the receptionist when completed. *NEW INSURANCE, ADDRESS, PHONE?)

For Administrative use only: Follow-up:_____ 99211 / 90833 / 99212 / 99213 / 90792 / 90875 /