

Recovery Phase			Clinician:
Date: - - d m yr		Present: <input type="checkbox"/> Client <input type="checkbox"/> Family: <input type="checkbox"/> Other:	Client:
			Location: <input type="checkbox"/> Office <input type="checkbox"/> Other:
Client	Family	Topics See education/psychosocial intervention section for overviews and handouts. <input type="checkbox"/> Psychosis <input type="checkbox"/> Etiology <input type="checkbox"/> Early Intervention <input type="checkbox"/> Medication <input type="checkbox"/> Psychosocial Treatments <input type="checkbox"/> Stress Management <input type="checkbox"/> Relapse Prevention - develop prevention plan as early on as possible <input type="checkbox"/> Social Functioning <input type="checkbox"/> Lifestyle <input type="checkbox"/> Goal Setting <input type="checkbox"/> Problem Solving <input type="checkbox"/> Drugs and Alcohol <input type="checkbox"/> Persistent Symptoms <i>Other (please indicate):</i> <input type="checkbox"/> _____	Progress Notes
	Individualized Care and Reintegration <ul style="list-style-type: none"> ● <i>Document:</i> <input type="checkbox"/> Progress made <input type="checkbox"/> Obstacles encountered <input type="checkbox"/> Revisions to individualized care or reintegration plans 		
	Ongoing Assessment <ul style="list-style-type: none"> ● <i>At least every 3 months:</i> <input type="checkbox"/> Assessment update completed using Update Template <input type="checkbox"/> 2-Com completed by client <input type="checkbox"/> Assess family impact and well-being <input type="checkbox"/> Review relapse prevention plan 		
	Other Care <ul style="list-style-type: none"> ● <i>Maintain regular contact with:</i> <input type="checkbox"/> General physician <input type="checkbox"/> Other care providers ● <i>Provide based on need or readiness</i> <input type="checkbox"/> Referrals for other services <input type="checkbox"/> Groups for client <input type="checkbox"/> Groups for family ● <i>If prolonged recovery is suspected</i> <input type="checkbox"/> Consult with psychiatrist <input type="checkbox"/> Document plans to change course 		
Please assess the following for every visit. Describe any changes or problems in notes.			
Mental Status	<input type="checkbox"/> no change	<input type="checkbox"/> improvement	<input type="checkbox"/> deterioration
Functioning	<input type="checkbox"/> no change	<input type="checkbox"/> improvement	<input type="checkbox"/> deterioration
Stress	<input type="checkbox"/> no change	<input type="checkbox"/> diminished stress	<input type="checkbox"/> increased stress/life event
Medication	<input type="checkbox"/> no problems	<input type="checkbox"/> side effects	<input type="checkbox"/> adherence issues