

| Recovery Phase | | | Clinician: Client: |
|--|--------------------------------------|--|---|
| Date: - - d m yr | | Present: <input type="checkbox"/> Client <input type="checkbox"/> Family: <input type="checkbox"/> Other: | Location: <input type="checkbox"/> Office <input type="checkbox"/> Other: |
| Client | Family | Topics | Progress Notes |
| | | 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 <input type="checkbox"/> Other (please indicate): _____ | |
| | | Individualized Care and Reintegration ● Document: <input type="checkbox"/> Progress made <input type="checkbox"/> Obstacles encountered <input type="checkbox"/> Revisions to individualized care or reintegration plans | |
| | | Ongoing Assessment ● At least every 3 months: <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 ● Maintain regular contact with: <input type="checkbox"/> General physician <input type="checkbox"/> Other care providers ● Provide based on need or readiness <input type="checkbox"/> Referrals for other services <input type="checkbox"/> Groups for client <input type="checkbox"/> Groups for family ● If prolonged recovery is suspected <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 |