

## Partners in Recovery

Appearance:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor				
Alert:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Cooperative:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Mood:	<input type="checkbox"/> Expansive	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Anxious	<input type="checkbox"/> Depressed	<input type="checkbox"/> Dysphoric
Affect:	<input type="checkbox"/> Labile	<input type="checkbox"/> Appropriate		<input type="checkbox"/> Blunt	<input type="checkbox"/> Flat		<input type="checkbox"/> Constricted
Thought Process:	<input type="checkbox"/> Logical	<input type="checkbox"/> Illogical		<input type="checkbox"/> Loose	<input type="checkbox"/> Concrete	<input type="checkbox"/> Tangential	<input type="checkbox"/> Circumstantial
<b>Perceptions:</b> Delusions:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Hallucinations:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
<b>Cognition:</b> Oriented:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Memory intact:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Judgment intact:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Insight intact:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Other Cognitive Impairment/ Confusion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Suicidal/Self Injurious:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Other injurious:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Psychosocial Stressors:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Substance or Alcohol Use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Appetite:	<input type="checkbox"/> Good	<input type="checkbox"/> Poor					
Sleep:	<input type="checkbox"/> Good	<input type="checkbox"/> Poor					
Med Compliance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Bubble Packs Provided	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Side Effects:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Movement Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Injections:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Labs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Physical Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Smoking Habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Social Leisure Activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Nursing Assess. Current	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Medical or PCP Medications:							
Nurse's Signature:				Member Name:			
Date:	Duration of Appointment:			Member I.D.:			

### NURSING PROGRESS NOTE

