Winding Oaks: Outpatient Morning Goals Reporting Form

Name:__________________________________ **Date:**________________

1) **What are your treatment goals for today? Any specific issues/topics you would like addressed?**

2) **Briefly described any triggers/issues you have experienced from last attending program? What tools did you use to manage them?**

3) **Rate the following during the last 24hrs ("0"=none and "10"=severe/unbearable/hospitalization)**
   a. **Irritability**...
   b. **Anxiety**...
   c. **Depression**..
   d. **Physical Pain**....................................
   e. **Auditory/Visual Hallucinations**........
   f. **Paranoia**...

4) **Self Harm**
   a. **Thoughts**...........................Yes No
   b. **Plan**..................................Yes No
   c. **Intent**...............................Yes No

   Suicidal Ideations
   a. **Thoughts**.................................Yes No
   b. **Plan**..Yes No
   c. **Intent**.......................................Yes No

5) **Have you used any alcohol/illicit drugs/non-prescribed medication within the last 24hrs** Yes No
   *Date of Sobriety:*__________________
   *If yes, what substances and how much:*_______________________________________

6) **Have you attended any support groups outside of The Oaks Outpatient Program within the last 24hrs?** Yes No
   *List:*____________________________________

7) **Total Hours of sleep last night:**________________ Rate: Poor, Restless, Broken, Restful

8) **Are you taking your medications as prescribed**: Yes No
   a. *If No, what is effecting your ability to take your medications as prescribed:*____

9) **Any adjustments in your medications within the last 24hrs:** Yes No
   a. *If Yes, what changes occurred*
   *List changes:*____

10) **Are you experiencing any side effects of the medication that has been prescribed for you**? Yes No
   a. *If you are having difficulty with your prescribed medications, did you fill out a pink slip to notify your provider?* Yes No

Reviewed by: __________________________________ **Date:**__________________________________
(Staff Signature)

Heritage Oaks Hospital **Winding Oaks Outpatient Services** **4300 Auburn Blvd., Sacramento, CA 95841** **(916)830-2224** **Outpatient Services Morning Report**	Patient Identification: