

**Gateway Community Health Center, Inc.**  
**Mental Health Progress Report-Health Promoter Follow-Up Form**

Patient Name: \_\_\_\_\_ ID # \_\_\_\_\_ Date: \_\_\_\_\_

Time Started: \_\_\_\_\_ Telephone Clinic Home Other \_\_\_\_\_

**\*NOTE: Be sure to obtain information on treatment plan prior to initiating Follow Up.**

**Weekly Follow Up:**

Are you feeling sad, depressed, or anxious?

- More than usual
- About the same
- Less than usual

What is the biggest thing troubling you right now? \_\_\_\_\_

How are you dealing with it? \_\_\_\_\_

***If any of the these are checked, contact provider immediately:***

<input type="checkbox"/>	Are you having any thoughts of harming yourself or of committing suicide? (Check if "yes")
<input type="checkbox"/>	(If medication is prescribed) Are you having thoughts or feelings that are going much faster than usual, or "racing"? (Check if "yes")
<input type="checkbox"/>	(If medication is prescribed) Are you sleeping two hours less than usual, and not being tired during the day? (Check if "yes")

***If medication is prescribed, ask the following:***

Have you filled the prescription for your medicine? If not checked, WHY?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What medicine for depression are you taking?	
How are you taking your medicine?	
Are you having any side effects or problems from your medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been going to your doctor or therapist appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Monthly Follow Up:** Administer PHQ (See PHQ page)

**Notes:**

\_\_\_\_\_  
\_\_\_\_\_

**Follow Up/Action:** \_\_\_\_\_

\_\_\_\_\_

Health Promoter: \_\_\_\_\_ Time Ended \_\_\_\_\_

**Note: If the patient answers yes to any of the three questions refer patient immediately to the Emergency Room and/or call 911.**