

Central State Hospital Activity Therapy Treatment Note

Name, Date, and Time of Group:

Client did not attend group: Date(s) and time (explanation in comment section)

TREATMENT GOAL NAME AND NUMBER

GROUP TYPE: Therapeutic Educational

GROUP CONTENT: (Staff Actions)

PROGRESS TOWARDS GOAL:

| Level of Participation | Cognition or Thinking Level | Behavioral Observations |
|--|--|--|
| <input type="checkbox"/> Positive group involvement <input type="checkbox"/> Makes positive self statements <input type="checkbox"/> Responds to staff encouragement <input type="checkbox"/> Responds appropriately to peers <input type="checkbox"/> Initiates conversation with staff/peers <input type="checkbox"/> Interacts non-verbally <input type="checkbox"/> Peripheral group participation <input type="checkbox"/> Participated with encouragement <input type="checkbox"/> Non-involved group participation <input type="checkbox"/> Listens attentively <input type="checkbox"/> Other: | <input type="checkbox"/> Follows complex directions <input type="checkbox"/> Follows simple directions <input type="checkbox"/> Organized thinking <input type="checkbox"/> Able to reminisce <input type="checkbox"/> Expresses delusions <input type="checkbox"/> Disorganized thinking <input type="checkbox"/> Responds to hallucinations <input type="checkbox"/> Other: | <input type="checkbox"/> Attentive; verbal <input type="checkbox"/> Attentive; quiet <input type="checkbox"/> Cooperative <input type="checkbox"/> Calm <input type="checkbox"/> Stable <input type="checkbox"/> Agitated <input type="checkbox"/> Disruptive, needed re-directive prompts <input type="checkbox"/> Anxious, needed support to maintain in group <input type="checkbox"/> Depressed <input type="checkbox"/> Angry <input type="checkbox"/> Other: |

| Motor Activity | Attention Span | Level of Understanding | Evaluation/Recommendations |
|---|--|---|---|
| <input type="checkbox"/> Able to sit entire session <input type="checkbox"/> Pacing <input type="checkbox"/> Wandering <input type="checkbox"/> Other: | <input type="checkbox"/> Able to focus <input type="checkbox"/> 5 Minutes <input type="checkbox"/> 10 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Can not focus | <input type="checkbox"/> Understands <input type="checkbox"/> Confused (Showed or voiced confusion) <input type="checkbox"/> Needs further instruction <input type="checkbox"/> Unable to adequately evaluate <input type="checkbox"/> Other: | <input type="checkbox"/> Client goal(s) met <input type="checkbox"/> Client goal(s) not met <input type="checkbox"/> Continued in next group session <input type="checkbox"/> Repeat group session <input type="checkbox"/> Refer for individual session <input type="checkbox"/> Refer for treatment plan revision <input type="checkbox"/> Other: |

ADDITIONAL COMMENTS:

Continue on back if necessary

Signature: _____

Title: _____

Stamp Plate