

McLaren Print System Order

Order No: 58440
Order Date: 2020-11-17
User: shirley liddell
Phone: 810-342-5333

Ship Location: McLaren OakBridge Center PHP - Shirley Liddell
4448 Oakbridge
FLINT, MI 48532

Forms

Quantity: 500
Paragon Dept No: 43560
Dept Name: McLaren OakBridge Center PHP
Company Number: 60

Order Total Price: 24.90

Item Number: 17641
Item Description: Daily Symptom Identification and Management Didactic
Revision Date: 2/2015
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info: This form is tumbled.

RELEASE 11/01
PARTIAL HOSPITALIZATION PROGRAM
DAILY SYMPTOM IDENTIFICATION AND MANAGEMENT DIDACTIC

1. Please rate your overall physical health today on a scale of 10 (very ill) to 1 (very healthy) _____
2. Please describe any physical symptoms or complaints you are experiencing this morning _____
3. How would you describe your appetite? Excellent Good Fair
4. How many meals have you eaten in the last 24 hours? _____
5. How many hours did you sleep last night? None 1-2 3-4 5 6 7 8 9 or more
6. Did you have difficulty falling asleep? Yes No
7. Did you have frequent awakenings during the night? Yes No
8. Did you have nightmares or bad dreams? Yes No
9. Do you take your medications as prescribed since the last time you were at PHP? Yes No
10. Did you take your medications as prescribed since the last time you were at PHP? Yes No
11. Have you had difficulties acquiring your medications from the pharmacy? Yes No
12. Have you experienced any side effects to your medications? Yes No
If yes, describe: _____
13. Have you consumed any alcoholic beverages since the last time you were at PHP? Yes No
If yes, what did you drink? _____ How many drinks? _____
14. Have you used other drugs (medicines, cocaine, etc) since the last time you were at PHP? Yes No
If yes, what and how much? _____
15. How would you describe your mood this morning? _____
16. If depressed, how severe is the depression on a scale of 1 to 10 (10 being most severe)? _____
17. If anxious, how severe is the anxiety on a scale of 1 to 10 (10 being most severe)? _____
18. Have you had a panic attack since the last time you were at PHP? Yes No
If yes, describe: _____
19. Have you experienced any confusion or disorientation recently? Yes No
20. Have you experienced racing thoughts or difficulty maintaining focus on a task? Yes No
21. Have you had thoughts of hurting yourself since the last time we saw you? Yes No
If yes, please describe what these thoughts are: _____
22. Have you had thoughts of hurting someone else? Yes No
If yes, please describe: _____
23. Have you heard voices or sounds that other people don't seem to hear? Yes No
If yes, what do you hear? _____
24. Have you had seen, smelled, or physically felt things that others do not? Yes No
If yes, please describe: _____
25. Have you had difficulty getting along with other people since the last time you were at PHP? Yes No
If yes, please describe: _____
26. Do you still have adequate food and shelter? Yes No
27. Do you feel you are benefiting from services of the Partial Hospital Program? Yes No

My personal goal for today is: _____

Client Name: _____ Date: ____/____/____

DAILY SYMPTOM IDENTIFICATION AND MANAGEMENT DIDACTIC
Form 1001-11-01 Rev 2/05


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