McLaren Flint
Behavioral Medicine

TREATMENT PLAN QUESTIONNAIRE

Please take a few moments to complete this questionnaire. The information you give will be used in the development of your individualized treatment plan.

1. What name do you wish the staff to use when they address you?
   - ❑ First Name
   - ❑ Title and Last Name

2. What are your reasons for seeking treatment at this time?

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3. What significant stresses or changes have you experienced in your life recently?

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4. What is your goal for treatment?

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5. Who is the most supportive person (or persons) in your life at this time?

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Do you wish to have this person involved in your treatment? ❑ YES ❑ NO
If yes, please check one of the following:

- ❑ I want the hospital staff to inform the person that I am here
- ❑ I want the hospital staff to talk to the person about my care and ask for their input
- ❑ I want the person to participate in the treatment team conference
- ❑ Other involvement (please describe)

____

5. Are you involved with a Case Management program such as CSI, TTI etc. If so would you like to have your case manager involved? ❑ Yes ❑ No What is your case manager's name and phone number?

____

NOTE: A Release of Information Form signed by the person receiving treatment is still needed

6. At your place of residence do you have adequate food? ❑ YES ❑ NO If no, please explain.

____

7. Do you have adequate housing? ❑ YES ❑ NO If no, please explain.

____

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PT.

MR.#/P.M.

DR.

8. Do you have adequate clothing? ❑ YES ❑ NO If no, please explain.

____

9. Do you have legal problems or need legal advice? ❑ YES ❑ NO If yes, please explain.

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10. Do you need assistance with gaining access to school or other educational opportunities:

❑ YES ❑ NO If yes, please explain.

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11. Do you need assistance in obtaining employment? ❑ YES ❑ NO If yes, please explain.

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12. Do you have adequate recreational opportunities? ❑ YES ❑ NO If no, please explain.

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13. **PHILOSOPHY REGARDING THE USE OF RESTRAINT AND/OR SECLUSION**
McLaren-Flint Behavioral Health is committed to preventing, reducing, and striving to eliminate the use of restraints and seclusion. This includes attempting to prevent emergencies that have the potential to lead to using seclusion or restraint. Lesser restrictive, nonphysical measures must be attempted prior to using seclusion or restraints. Restraints and seclusions are not used in outpatient programs. Restraints or seclusion will only be used when there is a significant risk of a person harming self, others or destroying property. Restraints and/or seclusion will be discontinued as soon as possible. Debriefing with staff and patient will occur after each episode of restraint or seclusion. The person's safety and dignity are of primary importance during the restraint or seclusion episode. In order to assist us in preventing an emergency that may lead to the use of restraints or seclusion, please help us by answering the following questions:

Please tell us any techniques and/or interventions you have found helpful in decreasing your anger or anxiety in the past:

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Please list your medical illnesses or physical disabilities, and, any history of physical or sexual abuse:

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____

Patient Signature Time/ Date

____

Family Member Signature Relationship to Patient Time/ Date

____

Staff Witness Time/Date

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