McLAREN FLINT
Flint, Michigan
OAK BRIDGE CENTER

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 feel rested this morning? ☐ 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 (marijuana, 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. Are you satisfied with your treatment at McLaren's Partial Hospital Program thus far? ☐ Yes ☐ No
27. Do you still have adequate food and shelter? ☐ Yes ☐ No
28. Do you feel you are benefiting from services at the Partial Hospital Program? ☐ Yes ☐ No

My personal goal for today is: ____
____

Client Name: ______________________________ Date _____ / _____ / _____

PT.

MR.#/P.M.

DR.

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CLINICAL OBSERVATIONS AND INTERVENTIONS (STAFF USE ONLY)

CODE: 1 = No problem or Mild; 5 = Moderate; 10 = Severe

Depression:	1 2 3 4 5 6 7 8 9 10
Anxiety:	1 2 3 4 5 6 7 8 9 10
Social Interaction:	1 2 3 4 5 6 7 8 9 10
Psychotic Symptoms:	1 2 3 4 5 6 7 8 9 10
Manic Symptoms (hyperverbal, restless, etc):	1 2 3 4 5 6 7 8 9 10
Concentration / Focus	1 2 3 4 5 6 7 8 9 10
Irritability / Anger	1 2 3 4 5 6 7 8 9 10
ADLS	1 2 3 4 5 6 7 8 9 10

Inadvertent risk to self, others, or property due to self-care, mood, thought or behavioral disorder?

Low Risk 1 2 3 4 5 6 7 8 9 10 High Risk

Has the client exhibited any new safety/health risks since attended day at PHP? ☐ Yes ☐ No

If yes, what are these risks? ______________________________

Significant regulation of medication and nursing intervention continues to exist? ☐ Yes ☐ No

Does client continue to meet Medical Necessity at the PHP level of care? ☐ Yes ☐ No

Evidence of Suicidality ☐ Yes ☐ No

Plan: ______________________________

Homicidality ☐ Yes ☐ No

Plan: ______________________________

Other observations, comments, or concerns: ______________________________

____

____

____

____

Staff Signature: ______________________________ Date/Time: ______________________________

DAILY SYMPTOM IDENTIFICATION AND MANAGEMENT DIDACTIC AND CLINICAL OBSERVATIONS AND INTERVENTIONS (STAFF USE ONLY)

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PT.

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DR.