McLaren
NORTHERN MICHIGAN

Patient Daily Self-Assessment

Please rate all questions based on the last 24 hours.

I commit to doing my 95% today: □ Yes □ No		Eating: □ Too Much □ Too Little □ Just Right	
Hours of Sleep: Tired: □ Yes □ No	Exercise Type:	Exercise Amount:	
Suicidal Thoughts: □ Yes □ No	Homicidal Thoughts: □ Yes □ No	Safety Plan in Place: □ Yes □ No	
Please rate your anxiety, depression and physical pain levels below.		Scale Guide: 0=None 10=Worst Ever	
Anxiety: 0 1 2 3 4 5 6 7 8 9 10	Depression: 0 1 2 3 4 5 6 7 8 9 10	Pain: 0 1 2 3 4 5 6 7 8 9 10	
Do you have any paperwork you need help filling out? □ No □ Yes, Explain:			
Do you have any appointments today or coming up? □ No □ Yes, What type/When:			
Do you need to see the psychiatrist/nurse practitioner? □ No □ Yes, Reason why:			
Energy: Up Down Normal	Taking Medications as Prescribed: □ Yes □ No Need Refills? □ Yes □ No Taking PRNs: □ Yes, Which one: _____ □ No Are you experiencing side effects? □ Yes, _____ □ No		
Today I feel:	Because:		
Which of the following symptoms are you experiencing?			
□ Depressed Mood □ Lack of Enjoyment □ Low Self Worth □ Poor Concentration □ Hopeless/Helpless	□ Isolating □ Crying □ Irritable/Angry □ Anxious □ Poor Hygiene	□ Muscle Tension □ Confusion □ Hallucinations □ Used Drugs/Alcohol □ Self Harm	□ Slowed Down □ Tired □ Panic Attacks □ Restless □ Binge Eating
Which of the following coping skills have you used?			
□ Drinking Water □ Eating a Healthy Diet □ Sleep Hygiene □ Exercise □ Following a Schedule □ Bathing/Brushing Teeth □ Journaling □ Attend 12 Step Program	□ Laughing □ Socializing □ Hobbies □ Practice Thought Stopping □ Practice Reframing Thoughts □ Identify Triggers □ Positive Self Talk □ Art Therapy/Coloring	□ Deep Breathing □ Mindfulness □ Positive Affirmations □ Practice Assertiveness □ No Drugs/Alcohol □ Support Group □ Attend appointments with doctor or therapist	
Daily Objective/Goal:			
Did you accomplish your goal from yesterday? □ Yes □ No			

Patient Signature: _____ Date:_____ Time:_____

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Nursing Comments:_____

_____

_____

Nurse Signature: _____ Date: _____Time: _____

Therapist Comments: _____

_____

_____

Therapist Signature: _____Date: _____Time:_____

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