

McLaren Print System Order

Order No: 81506
 Order Date: 2023-12-06
 User: Brooke Pearson
 Phone: 2316271370

Ship Location: McLaren Cheboygan- BHU Attn: Brooke Pearson
 748 South Main St
 Cheboygan, Mi 49721

Forms

Quantity: 500
 Paragon Dept No: 30462
 Dept Name: BHU
 Company Number: 410

Order Total Price: 22.40

Item Number: MHCC-678-MNM
 Item Description: PHP Patient Daily Assessment
 Revision Date: 06/2023
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info: DS, Black



Patient Daily Self-Assessment

Please rate all questions based on the last 24 hours.

I consent to using my NHS today: Yes No Eating: Too Much Too Little Just Right

Hours of Sleep: 7-8 6 5 4 3 2 1 0 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: Circle: Outside 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/where: _____

Do you need to see the psychiatrist/nurse practitioner? No Yes, Reason why: _____

Energy: Up Down Normal Taking Medications as Prescribed: Yes No Need Refill? 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?

<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Irritability	<input type="checkbox"/> Muscle Tension	<input type="checkbox"/> Slowed Down
<input type="checkbox"/> Lack of Enjoyment	<input type="checkbox"/> Crying	<input type="checkbox"/> Confusion	<input type="checkbox"/> Tired
<input type="checkbox"/> Low Self Worth	<input type="checkbox"/> Irritable/Angry	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Anxious	<input type="checkbox"/> Used Drugs/Alcohol	<input type="checkbox"/> Restless
<input type="checkbox"/> Hopeless/Helpless	<input type="checkbox"/> Worry Excessive	<input type="checkbox"/> Self Harm	<input type="checkbox"/> Weight Fluctuating

Which of the following coping skills have you used?

<input type="checkbox"/> Drinking Water	<input type="checkbox"/> Laughing	<input type="checkbox"/> Deep Breathing
<input type="checkbox"/> Eating a Healthy Diet	<input type="checkbox"/> Socializing	<input type="checkbox"/> Mindfulness
<input type="checkbox"/> Sleep Hygiene	<input type="checkbox"/> Hobbies	<input type="checkbox"/> Positive Affirmations
<input type="checkbox"/> Following a Schedule	<input type="checkbox"/> Practice Thought Stopping	<input type="checkbox"/> Practice Assertiveness
<input type="checkbox"/> Bathing/Brushing Teeth	<input type="checkbox"/> Practice Reframing Thoughts	<input type="checkbox"/> No Drugs/Alcohol
<input type="checkbox"/> Journaling	<input type="checkbox"/> Identify Triggers	<input type="checkbox"/> Support Group
<input type="checkbox"/> Attend 12 Step Program	<input type="checkbox"/> Positive Self Talk	<input type="checkbox"/> Attend appointments with doctor or therapist
<input type="checkbox"/> Art Therapy/Coloring		

Daily Objective/Goal: _____

Did you accomplish your goal from yesterday? Yes No

Spec Info:

Patient Signature: _____ Date: _____ Time: _____

