McLaren Business Products

McLaren Print System Order

Order No: 82090
Order Date: 2024-01-04
User: Brooke Pearson
Phone: 2316271370

Ship Location: McLaren Cheboygan- BHU Attn: Brooke Pearson
748 South Main St
Cheboygan, Mi 49721
Forms
Quantity: 1000
Paragon Dept No: 30462
Dept Name: BHU
Company Number: 410

Order Total Price: 46.00

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: 2 Hole Top
Poster:
Misc Info: DS, Black

Spec Info:

McLaren
NORTHERN MICHIGAN

Patient Daily Self-Assessment

Please rate all questions based on the last 24 hours.

I commit to doing my SMART 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	○ Isolating	○ Muscle Tension	○ Slowed Down
○ Lack of Enjoyment	○ Crying	○ Confusion	○ Tired
○ Low Self Worth	○ Irritable/Angry	○ Hallucinations	○ Panic Attacks
○ Poor Concentration	○ Anxious	○ Used Drugs/Alcohol	○ Restless
○ Hopeless/Helpless	○ Poor Hygiene	○ Self Harm	○ Binge Eating

Which of the following coping skills have you used?

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

Daily Objective/Goal:

Did you accomplish your goal from yesterday? ○ Yes ○ No

Patient Signature: Date: Time: