

McLaren Print System Order

Order No: 89879
 Order Date: 2024-11-12
 Order Request Date:
 User: Brooke Pearson
 Phone: 2316271370

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

Brochures
 Quantity: 1000
 Paragon Dept No: 30462
 Dept Name: BHU
 Company Number:

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



Patient Daily Self-Assessment

Please rate all questions based on the last 24 hours.

I consent to using my VNA today: Yes No Not Applicable 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 turn any paperwork you need to be 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 physician/nurse practitioner? No Yes, Reason why: _____

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

Taking PRN: 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"/> Irritating	<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"/> Don't Feel Well	<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"/> Poor Hygiene	<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Binge Eating

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"/> Exercise	<input type="checkbox"/> Practice Thought Stopping	<input type="checkbox"/> Practice Awareness
<input type="checkbox"/> Following a Schedule	<input type="checkbox"/> Practice Reframing Thoughts	<input type="checkbox"/> No Drugs/Alcohol
<input type="checkbox"/> Bathing/Brushing Teeth	<input type="checkbox"/> Identify Triggers	<input type="checkbox"/> Support Group
<input type="checkbox"/> Journaling	<input type="checkbox"/> Positive Self Talk	<input type="checkbox"/> Attend appointments with doctor or therapist
<input type="checkbox"/> Attend 12 Step Program	<input type="checkbox"/> Art Therapy/Coloring	

Daily Objective/Goal: _____

Did you accomplish your goal from yesterday? Yes No

Patient Signature: _____ Date: _____ Time: _____

Spec Info:

