

McLaren Flint
FLINT, MICHIGAN
Behavioral Medicine

TREATMENT PLAN QUESTIONNAIRE

Please take a few moments to complete this questionnaire. The information you give will be used in the development of your individualized treatment plan.

1. By what name do you wish the staff to use when they address you?

- First Name
- Title and Last Name

2. What are your reasons for seeking treatment services at this time?

3. What significant stresses or changes have you experienced in your life recently?

4. Who is the most supportive person (or persons) in your life at this time? _____

Do you wish to have this person involved in your treatment? YES NO

If yes, please check one of the following:

- I want the hospital staff to inform the person that I am here
- I want the hospital staff to talk to the person about my care and ask for their input
- I want the person to participate in the treatment team conference
- Other involvement (please describe)

5. Are you involved with a Case Management program such as CSI, TTI etc. If so would you like to have your case manager involved? What is your case manager's phone number?

NOTE: A Release of Information Form signed by the person receiving treatment is still needed

6. At your place of residence do you have adequate food? YES NO If no, please explain.

7. Do you have adequate housing? YES NO If no, please explain.

8. Do you have adequate clothing? YES NO If no, please explain.

9. Do you have legal problems or need legal advice? YES NO If yes, please explain.



PT.

MR.#/RM.

DR.

DR.

MR./RM.

PT.

Staff Witness

Date

Family Member Signature

Relationship to Patient

Date

Patient Signature

Date

Please list your medical illnesses or physical disabilities, and, any history of physical or sexual abuse:

Please tell us any techniques and/or interventions you have found helpful in decreasing your anger or anxiety in the past:

McLaren Regional Medical Center is committed to preventing, reducing and striving to eliminate the use of restraints and seclusion. This includes attempting to prevent emergencies that have the potential to lead to the use of seclusion or restraint. Lesser restrictive, nonphysical measures must be attempted prior to the using seclusion or restraints. Restraints and seclusion are not used in outpatient programs. Restraints and seclusions are not used in outpatient programs. Restraints will only be used when there is a significant risk of a person harming self, others or destroying property. Seclusion will only be used when there is a significant risk of a person harming others or destroying property. Restraints and/or seclusion will be discontinued as soon as possible. Staff will be made aware of the person's feedback regarding the restraint or seclusion experience. The person's safety and dignity are of primary importance during the restraint or seclusion episode. In order to assist us in preventing an emergency that may lead to the use of restraints or seclusion, please help us by answering the following questions:

13. PHILOSOPHY REGARDING THE USE OF RESTRAINT AND/OR SECLUSION

12. Do you have adequate recreational opportunities? YES NO If no, please explain.

11. Do you need assistance in obtaining employment? YES NO If yes, please explain.

10. Do you need assistance with gaining access to school or other educational opportunities? YES NO If yes, please explain.