

McLaren Print System Order

Order No: 6462
 Order Date: 2014-10-14
 User: Terri Harding
 Phone: 801-653-2000

Ship Location: Davison PT/Terri Harding
 505 N Dayton Street
 Davison, MI 48423

Forms

Quantity: 100
 Paragon Dept No: 38112
 Dept Name: McLaren Flint Davison PT
 Company Number: 60

Order Total Price: 0.00

Item Number: MHCC-1781 A
 Item Description: Patient Self-Assessment
 Revision Date:
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

McLaren Flint
 Flint, Michigan 48406
THERAPY SERVICES RECORD
 Patient Self-Assessment

** Please complete as thoroughly as possible. This information will remain confidential.

Height: _____ Weight: _____ Right / Left Handed: _____ Occupation: _____
 Why are you here? _____
 Date of onset for this problem _____ Is this Auto / Work / Sports related? _____
 At the present time, would you say that your health is: excellent good fair poor? _____
 Have you had therapy or any other treatment for this problem (i.e., chiropractic, injections, brace, orthotic, splint) _____
 Do you have any equipment at home that you routinely use? (cane, walker, wheelchair, tub seat, TENS unit) _____
 Have you had any recent tests? (i.e., X-ray, MRI, EMG, CT Scan, bone scan, blood work) _____
 Do you have a pacemaker, metal or other implants in your body? Yes No
 Do you smoke? Yes No
 If you are a female, is there any possibility that you are pregnant? Yes No
 If you are having pain, shade in the painful area on the chart.
 Please check if you have a history of any of the following:

| Diagnosis / Condition | Yes | Diagnosis / Condition | Yes |
|------------------------|-----|-----------------------|-----|
| Stomach Disorders | | High Blood Pressure | |
| Bleeding Disorders | | Heart Disease | |
| Asthma/Lung Disease | | Diabetes | |
| Depression/Anxiety | | Cancer - tumor lump | |
| Blood Clot | | Osteoporosis | |
| Neck/Shoulder Problems | | Arthritis | |
| Measles, HIV | | Seizure Disorder | |
| Thyroid | | High Cholesterol | |
| Autoimmune | | Skin Disorder | |
| Fractures | | Other | |

List any past surgeries (include dates): _____

 List any known allergies (latex, tape, lotion, medications, see string): _____
 Do you have any difficulty with vision or hearing? Yes No
 Have you fallen within the last year? Yes No
 Did any fall result in injury? Yes No
 Do you feel unsafe with your partner or anyone else? Yes No
 Have you ever been verbally, emotionally, physically, or sexually harmed, threatened or financially exploited by your partner or anyone else?
 Yes No

Office Use Only:
 Intervention/Referral:
 None needed
 Educational packet issued
 Put off file
 Abuse/Neglect resources
 Other: _____

THERAPY SERVICES RECORD
 MHCC-1781-0000