McLaren Business Products

McLaren Print System Order

Order No: 7687 Reprint Previous Order No: 6457
Order Date: 2014-12-17
User: Terri Harding
Phone: 810-653-2000

Ship Location: Davison PT/Terri Harding
505 N. Dayton
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: 6/2014
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Flint

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	
Bowel/Bladder Problem		Arthritis	
Hepatitis, 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, bee sting): _____

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/follow up:
❑ None needed
❑ Educational packet issued
❑ Fall Risk
❑ Abuse/Neglect resources
❑ Other: _____

THERAPY SERVICES RECORD