

McLaren Print System Order

Order No: 44386
 Order Date: 2019-04-10
 User: Susan Hillger
 Phone: 248-866-2048

Ship Location: McLaren Flint PT (attn: Doris Duncan)
 G-3239 Beecher Rd
 Flint, MI 48532

Forms

Quantity: 1000
 Paragon Dept No: 38110
 Dept Name: McLaren Flint PT
 Company Number: 60

Order Total Price: 0.00

Item Number: MHCC-1781 A
 Item Description: Patient Self-Assessment
 Revision Date: 4/2015
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

McLaren Flint
 Form MHCC-1781 A
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	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Asthma/Lung Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	Cancer - tumor/kump	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Neck/Shoulder Problems	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Measles, HIV	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Autoimmune	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	Other	<input type="checkbox"/>

List any past surgeries (include dates): _____

 List any known allergies (latex, tape, lotion, medications, see string): _____

Spec Info: 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/Authorship: _____
 None needed
 Educational packet issued
 Put of file
 Abuse/Neglect resources
 Other: _____

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