

McLaren Print System Order

Order No: 44508
Order Date: 2019-04-15
User: roman kinal
Phone: 248 922-6820

Ship Location: McLaren Oakland - Clarkston PT dept
5701 Bow Pointe Dr. Ste 310
Clarkston, mi 48346

Forms

Quantity: 500
Paragon Dept No: 8437
Dept Name: Clarkston PT and Sports Medicine
Company Number: 310

Order Total Price: 32.50

Item Number: 1781-B
Item Description: Therapy Services Record Patient Self-Assessment
Revision Date: 4/2019
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info: Print single sided (2 pages)

McLaren Oakland
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? _____

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

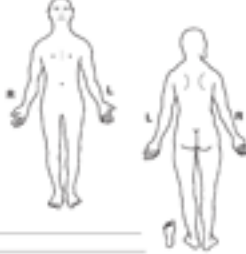
Do you smoke? Yes No

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/lump	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Bladder/Bladder Problem	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Hepatitis, HIV	<input type="checkbox"/>	Stroke 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, bee stings) _____

Do you have any difficulty with vision or hearing? 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/breastfed or financially exploited by your partner or anyone else? Yes No

Yes No

Office Use Only:

Intervention/ follow-up: None needed

Educational packet issued

Fall Risk

Abuse/Neglect resources

Other _____

Spec Info:

THERAPY SERVICES RECORD



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