McLaren Business Products

McLaren Print System Order

Order No: 46376
Order Date: 2019-06-20
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)

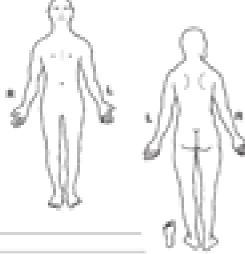
McLaren Oakland
THERAPY SERVICES RECORD

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		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	

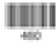


List any past surgeries (include dates): ________________

List any known allergies: (latex, tape, lotion, medications, bee sting): ________________
Do you have any difficulty with vision or hearing? ☐ Yes ☐ No
...n 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



Spec Info: