

**McLaren Print System Order**

**Order No: 59714**  
**Order Date: 2021-01-18**  
**User: Jennifer Teeling**  
**Phone: 248-922-6820**

**Ship Location: McLaren Physical Therapy Clarkston**  
**5701 Bow Pointe Suite 310**  
**Clarkston, Michigan 48346**

**Forms**

**Quantity: 1000**  
**Paragon Dept No: 8437**  
**Dept Name: Physical Therapy Clarkston**  
**Company Number: 310**

**Order Total Price: 60.00**

**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

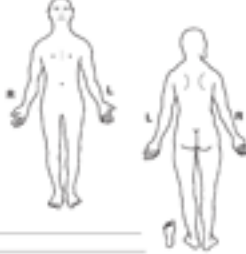
Do you smoke?  Yes  No

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	
Bladder/Bladder Problem		Arthritis	
Hepatitis, HIV		Stroke Disorder	
Thyroid		High Cholesterol	
Autoimmune		Skin Disorder	
Fractures		Other	



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



480