McLaren Flint
FLINT, MICHIGAN 48532

PATIENT INTERVIEW AND HISTORY

(PLEASE PRINT)
Patient Name: _____ **Birth Date:** ____ / ____ / ____

Yes	No		Yes	No	
❑	❑	Pacemaker * If Yes Please Notify Staff *	❑	❑	Stroke
❑	❑	Cardiac Defibrillator (ICD) * If Yes Please Notify Staff *	❑	❑	Seizures
❑	❑	Brain Aneurysm Clips * If Yes Please Notify Staff *	❑	❑	Diabetes
❑	❑	Ear Surgery	❑	❑	High Blood Pressure
❑	❑	Metal in Body or Eyes	❑	❑	Arthritis
❑	❑	Surgical Implants	❑	❑	Pregnancy
❑	❑	Prosthesis	❑	❑	Kidney Disease
❑	❑	Abdominal Aortic Aneurysm Surgery (Year: _____)	❑	❑	Allergies *if yes_____
❑	❑	History of Cancer (Type: _____) (When Diagnosed: _____)			
❑	❑	Does patient require additional assistance? Explain _____			

Patient's Signature: _____ **Date:** ____ / ____ / ____

⬇********** OFFICE USE ONLY **********⬇

Exam: _____ **Diagnosis:** _____

Pertinent Surgeries and Dates: _____

Current Signs, Symptoms, Location: _____

_____

_____

❑ **Non-Traumatic?** **Date of onset:** _____

❑ **Traumatic?** **Date of injury:** _____

Ht: _____

Wt: _____

CONTRAST DOSAGE _____

Type of injury: ❑MVA ❑Sports ❑Lifting ❑Fall ❑Other: _____

Severity of Pain: ❑ Mild ❑ Moderate ❑Severe (Severity: _____/10)

Physical Therapy: ❑No ❑Yes ❑Beneficial ❑ Somewhat beneficial ❑Non-beneficial

Medications: _____

Other Tests for current medical condition: _____

_____

Interviewer: _____ **Date:** ____ / ____ / ____

PT.

MR.#/RM.

DR.