

McLaren Print System Order

Order No: 73831
 Order Date: 2022-11-29
 User: Jennifer Teeling
 Phone: 248-922-6820

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

Forms

Quantity: 1000
 Paragon Dept No: 26900-2280
 Dept Name: Physical Therapy
 Company Number: 310

Order Total Price: 65.00

Item Number: 1781-B
 Item Description: Therapy Services Record Patient Self-Assessment
 Revision Date: 8/2021
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: 2 Hole Top
 Poster:
 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, spine) _____

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

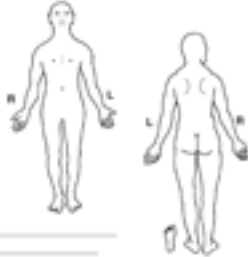
Do you smoke? Yes No

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 - (neck/throat)	
Blood Clot		Osteoporosis	
Bowel/Bladder Problem		Arthritis	
Hepatitis, HIV		Seizure Disorder	
Thyroid		High Cholesterol	
Autoimmune		Skin Disorder	
Fractures		Other	



List any past surgeries (include date): _____

Spec Info: (press dates, tape, lotion, medications, toe string)

Do you have any 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/Follow up:

None needed

Educational packet issued

Fall Risk

Abuse/Neglect resources

Other _____