McLaren Business Products

McLaren Print System Order

Order No: 76928
Order Date: 2023-04-27
User: Laura Love
Phone: 989-894-3936

Ship Location: East Medical Mall Attn: Laura Love
1454 W. Center Road
Essexville, MI 48732
Forms
Quantity: 100
Paragon Dept No: 79029
Dept Name: Community Health Services
Company Number: 210

Order Total Price: 18.95

Item Number: B-141
Item Description: Balance Screening Form
Revision Date: 04/2023
Print: 1 sided black and white
Paper: 3 Part (White, Yellow, Pink)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info:

Spec Info:

McLaren

Balance Screening Registration & Consent Form

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Gender: _____ Date of Birth: ____/____/____ Height: _____ Weight: _____ Email: _____

Primary Physician: _____

Release of Liability

I understand that I am voluntarily requesting to participate in the McLaren Balance Screening. I agree to voluntarily release McLaren, their employees, agents, volunteers, and other persons acting in any capacity on their behalf, from any and all claims or causes of action which are in any way connected to my participation in this screening. I accept all responsibility for the evaluation, future scheduling and costs of future medical evaluation, diagnostic tests and treatment in addition to the pursuit of any recommendations provided. I understand that this screening is not intended to be a complete balance examination. McLaren may use the results of this screening for statistical and educational purposes, but my name will not be released to any person or organization without my express written consent.

Participant Signature: _____ Date: _____

1. How many times have you fallen within the past 12 months? _____
If you have fallen in the past 12 months, please provide a detailed description of 1 or 2 incidents as you remember it.

Fall #1: (a) Date: _____
(b) Location (e.g., Bathroom, garden, grocery store):
_____
(c) Reason for fall (e.g., uneven surface, going downstairs, pain):
_____

Fall #2: (a) Date: _____
(b) Location (e.g., Bathroom, garden, grocery store):
_____
(c) Reason for fall (e.g., uneven surface, going downstairs):
_____

How concerned are you about falling?
1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Not at all Moderately Extremely

2. In the past 4 weeks, to what extent did health problems limit your everyday physical activities (such as walking and household chores)?
Not at all (1) Slightly (2) Moderately (3) Quite a bit (4) Extremely (5)

3. Do you currently require household or nursing assistance to carry out daily activities?
Yes No
If yes, please list the reason(s): _____

4. Do you currently participate in regular physical activity that is strenuous enough to cause a noticeable increase in breathing, heart rate, or perspiration? Yes No
If yes, how many days per week? One Two Three Four Five Six Seven

5. In general, how would you rate the quality of your life?
1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Very Low Low Moderate High Very High