McLaren Flint
FLINT, MICHIGAN 48532
McLaren Neuro Rehabilitation Institute

PATIENT SELF-ASSESSMENT

What accident/injury brings you here today?_____

What treatments are you getting now? _____

Were you hospitalized for this condition? ☐ **Yes** ☐ **No**

When and Where?_____

At the present time, would you say that your heath is (circle answer): excellent good fair poor?

Medical History

Diagnosis/Condition	Diagnosis/Condition

Surgical History

Surgery	Date of Surgery

Current Functional Issues: *Please check all that apply.*

☐ Dizziness / Vertigo	☐ Double / Blurry vision	☐ Chewing / Swallowing problems
☐ Balance / Coordination issues	☐ Memory Issues	☐ Depression / Anxiety / Irritability
☐ Walking / Transfer difficulty	☐ Concentration problems	☐ Anger / Impulse control
☐ Muscle weakness	☐ Organization	☐ Suicidal thoughts / Attempts
☐ Arm	☐ Communication difficulty	☐ Reliving / Dreams of trauma
☐ Leg	☐ Difficulty with self care	☐ Alcohol / Drug abuse
☐ Headaches	☐ Difficulty with home chores	☐ Smoking dependence
☐ Visual deficits / Glasses / Contacts	☐ Sleep disturbances	☐ Hearing deficits / Hearing aide

Please answer the following questions:

Do you have a pacemaker? ☐ **Yes** ☐ **No**

Do you have any metal or other implants in your body? *(pins, plates, screws)* ☐ **Yes** ☐ **No**

Do you wear any splints or braces? ☐ **Yes** ☐ **No**

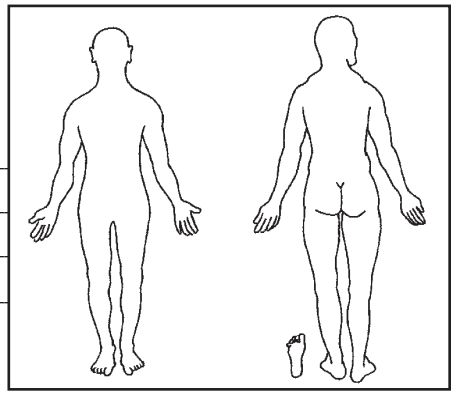
Do you feel afraid or unsafe with your partner or anyone else? ☐ **Yes** ☐ **No**

Have you been verbally, emotionally, physically, or sexually harmed/threatened by your partner or anyone else? ☐ **Yes** ☐ **No**

Have you been financially exploited by your partner or anyone else? ☐ **Yes** ☐ **No**

Have you had 1 or more falls in the past 6 months? ☐ **Yes** ☐ **No**

If you are having pain please indicate the location on the chart:



Describe your pain?_____

_____

What is your goal for therapy?_____

_____

Signature: _____ Date: _____

Reviewed By:_____ Date: _____

PATIENT SELF-ASSESSMENT
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PT.

MR.#/RM.

DR.