McLaren Business Products

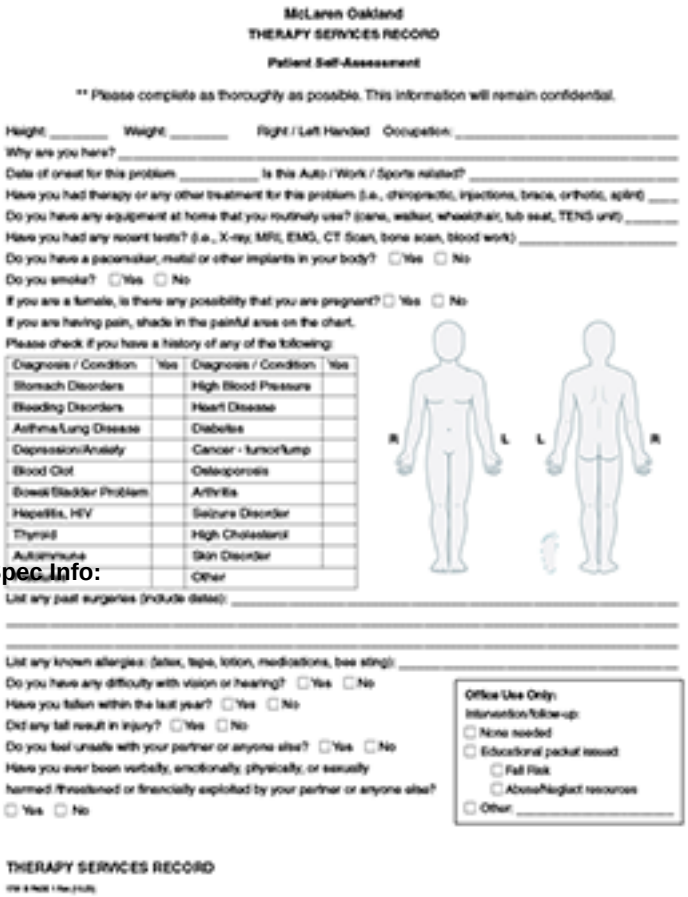
McLaren Print System Order

Order No: 81107
Order Date: 2023-11-13
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: 60.00

Item Number: 1781-B
Item Description: Therapy Services Record Patient Self-Assessment
Revision Date: 10/2023
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
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, 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	
Bowel/Bladder Problem		Arthritis	
Hepatitis, HIV		Seizure Disorder	
Thyroid		High Cholesterol	
Autoimmune		Skin Disorder	
Stroke		Other	

R L L R

List any past surgeries (include dates): _____
_____
_____
List any known allergies: (latex, tape, lotion, medications, bee sting): _____
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: _____

THERAPY SERVICES RECORD

Spec Info: