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

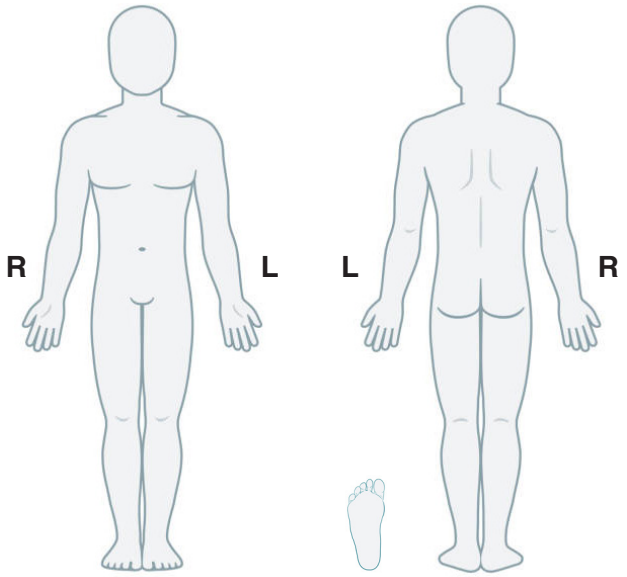
Do you smoke? ☐ Yes ☐ No

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	
Fractures		Other	



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: _____

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List Medications: (include prescription, non-prescription and herbal supplements)

☐ See attached list

Current Medication List

By signing, I certify that this assessment form is accurate to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Best contact number Email Address

How did you hear about us?

☐ Doctor's Office ☐ Community Event ☐ Internet Search/Website

☐ Relative/Friend: _____

☐ Other: _____

Patient Assessment Reviewed:

_____ _____ _____
Therapist Signature Date Time

Discharge Information:

Discharge Date (last date of service) _____ Therapist Initials _____ Date _____

Office Initials & Date _____