

McLaren Print System Order

Order No: 90380
Order Date: 2024-11-26
Order Request Date:
User: Jennifer Teeling
Phone: 248-568-3849

Ship Location: McLaren Physical Therapy Clarkston
5701 Bow Pointe Dr Suite 300
Clarkston, Michigan 48346

Brochures
Quantity: 500
Paragon Dept No: 26900-2280
Dept Name: Physical Therapy
Company Number:

Order Total Price: 32.50

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, or photo, spinal) _____

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

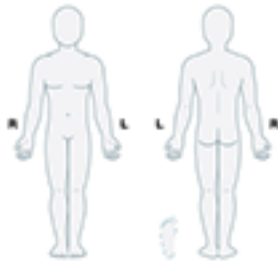
Do you smoke? Yes No

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

Spec Info: Please ensure these are single sided, 2 pages. Thank you.