

**McLaren Print System Order**

**Order No: 44943**  
**Order Date: 2019-04-30**  
**User: Jennifer Teeling**  
**Phone: 2489697360**

**Ship Location: McLaren Oakland Oxford Physical Therapy**  
**385 N Lapeer Rd**  
**Oxford, Michigan 48371**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 0441**  
**Dept Name: Physical Therapy**  
**Company Number: 310**

**Order Total Price: 32.50**

**Item Number: 1781-B**  
**Item Description: Therapy Services Record Patient Self-Assessment**  
**Revision Date: 4/2019**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**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

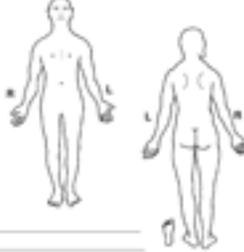
Do you smoke?  Yes  No

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        |     | Secure Disorder       |     |
| Thyroid               |     | High Cholesterol      |     |
| Autoimmune            |     | Skin Disorder         |     |
| Fractures             |     | Other                 |     |



List any past surgeries (include dates): \_\_\_\_\_

List any known allergies: (latex, tape, lotion, medications, bee stings) \_\_\_\_\_

Do you have any difficulty with vision or hearing?  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:**

Case record

Educational packet issued

Fall Risk

Abuse/Neglect resources

Other \_\_\_\_\_

**Spec Info: Deliver to Physical Therapy Dept**

