

McLaren Print System Order

Order No: 60437
 Order Date: 2021-02-19
 User: Susan Hillger
 Phone: 248-866-2048

Ship Location: McLaren PT (Janel Anderson)
 G-3239 Beecher Rd
 Flint , MI 48532

Forms

Quantity: 1000
 Paragon Dept No: 38260
 Dept Name: McLaren Flint - NRI
 Company Number: 60

Order Total Price: 0.00

Item Number: 17619
 Item Description: Patient Self-Assessment
 Revision Date: 6/2014
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

McLaren Flint
 Flint, Michigan 48906
 McLaren Reum 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 health is (circle answer): excellent good fair poor?

Medical History		Surgical History	
Neurological	Cardiovascular	Spine	Other Surgery

- Current Functional Issues:** Please check all that apply.
- | | | |
|---------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Double / Blurry vision | <input type="checkbox"/> Chewing / Swallowing problems |
| <input type="checkbox"/> Balance / Coordination issues | <input type="checkbox"/> Memory issues | <input type="checkbox"/> Depression / Anxiety / Irritability |
| <input type="checkbox"/> Walking / Transfer difficulty | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Anger / Impulse control |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Organization | <input type="checkbox"/> Suicidal thoughts / Attempts |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Communication difficulty | <input type="checkbox"/> Reliving / Dreams of trauma |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Difficulty with self care | <input type="checkbox"/> Alcohol / Drug abuse |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Difficulty with home chores | <input type="checkbox"/> Smoking dependence |
| <input type="checkbox"/> Visual deficits / Glasses / Contacts | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Hearing deficits / Hearing aids |

Please answer the following questions:
 Do you have a pacemaker? Yes No
 Do you have any metal or other implants in your body? (arm, joint, 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

Spec Info:

If you are feeling pain please indicate the location on the chart.
 Describe your pain?
 What is your goal for therapy?
 Reported by _____ Date _____
 Reviewed by _____ Date _____



PATIENT SELF-ASSESSMENT
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