

## McLaren Print System Order

Order No: 9593  
 Order Date: 2015-03-05  
 User: Yvonne Mulcahy  
 Phone: 22565

Ship Location: McLaren Flint- 1 north-OUTPT Physical Therapy  
 401- S Ballenger Hwy  
 Flint, MI 484532

### Forms

Quantity: 500  
 Paragon Dept No: 38110  
 Dept Name: Physical therapy  
 Company Number: 60

Order Total Price: 24.90

Item Number: MHCC-1781 A  
 Item Description: Patient Self-Assessment  
 Revision Date: 6/2014  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: 5 Hole Top  
 Misc Info:

McLaren Flint  
 Flint, Michigan 48453  
**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? \_\_\_\_\_  
 At the present time, would you say that your health is: excellent good fair poor? \_\_\_\_\_  
 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	
Neck/Shoulder Problem		Arthritis	
Measles, 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, see string): \_\_\_\_\_  
 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/Referral:  None needed  
 Educational packet issued  
 Put of file  
 Abuse/Neglect resources  
 Other: \_\_\_\_\_

THERAPY SERVICES RECORD  
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