**McLaren Lapeer Region**
LAPEER, MI 48446

## THERAPY SERVICES RECORD

AGE:_______________ Sex: ☐ Male ☐ Female Date of Record________________

| Diagnosis, including Diagnosis Pertaining to Physical Therapy Treatment | | |
|---|---|---|
| **DATE OF PRESCRIPTION** | **TREATMENT(S) REQUESTED** | **Physician's Signature** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| BILL (R) PATIENT REFUSED (/0 ONCE DAILY (X) TWICE DAILY (N/S) DID NOT SHOW (C) CANCELLED | | |
| **DAILY RECORD** | | |

| MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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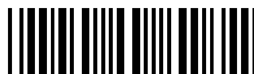
☐ SPEECH THERAPY

☐ PHYSICAL THERAPY

☐ OCCUPATIONAL THERAPY

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**THERAPY SERVICES RECORD**

Do you have a history of back/neck Pain? YES NO When?____________________
Do you have any metal implants? YES NO Where?____________________
Do you smoke? YES NO How much per day?____________________
Do you exercise regularly? YES NO WHEN?____________________
Are you allergic to latex? YES NO
Are you pregnant or suspect pregnancy? YES NO

8. In the past year have you had any of the following medical tests?

| | | | |
|---|---|---|---|
| XRAY | ___________ | EMG | ___________ |
| MRI | ___________ | Bone Scan | ___________ |
| CT Scan | ___________ | Bone Density | ___________ |
| Blood Work | ___________ | Doppler Ultrasound | ___________ |
| Stress Test | ___________ | Pulmonary Function Test | ___________ |
| EEG | ___________ | Other: | ___________ |

9. Do you use any of the following equipment on a regular basis?

| | | | |
|---|---|---|---|
| Cane | ___________ | Tub Bench | ___________ |
| Walker | ___________ | TENS Unit | ___________ |
| Wheelchair | ___________ | Brace | ___________ |

Adaptive equipment such as grab bar or reacher ___________

10. Surgical History:____________________________________________

____________________________________________

____________________________________________

11. Current Medication:____________________________________________

____________________________________________

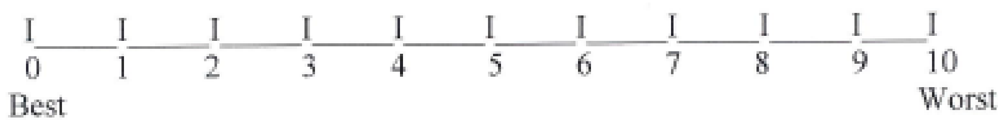
____________________________________________

12. Medications Allergies:____________________________________________

13. Have you fallen within the last year? YES ___________ NO ___________
If YES, were you injured? YES ___________ NO ___________

14. Pain Rating: If you have pain, what is your pain level? (0 = no pain, 10 = extreme pain)

Pain level at **WORST** **(circle)**



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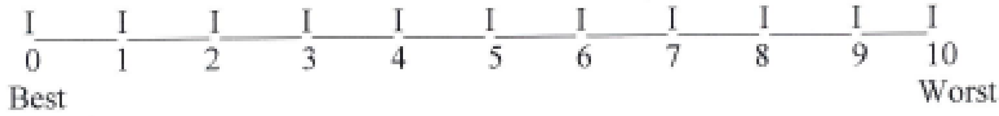
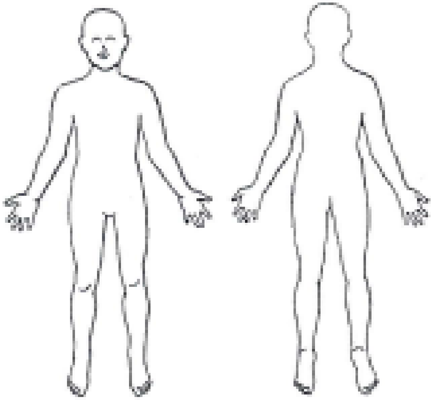
**THERAPY SERVICES RECORD**

Pain level at **BEST** (circle)




15. Mark the location of your pain with an **X**:



16. Hand dominance: RIGHT __________ LEFT __________

17. Do you have a pacemaker or a defibrillator? YES __________ NO __________

18. Please rate your overall health:

| | | | |
|---|---|---|---|
| Excellent | __________ | Fair | __________ |
| Good | __________ | Poor | __________ |

19. Height: __________ Weight: __________

20. What are your goals for therapy? ____________________________________________________________

21. Who can we leave a message with (if necessary)?
Name: ______________________ Phone Number: ______________________

22. Please provide the best phone number in which to contact you (if necessary)
______________________________________________

Patient Signature: ________________________________ Date: ________________

Therapist Signature: ______________________________ Date: ________________