Patient Name:________________________ DOB:____________ DATE: ______________

Current Medications List

Please include ALL prescriptions, over the counter medications, herbals, and vitamin/mineral/dietary nutritional supplements.

Medication Name	Dosage (25 mg, etc.)	Frequency (3x per day, etc.)	Route of Administration (by mouth, etc.)	Prescribing MD
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

A Continued Medication List page is available for any additional medications

Have you had any falls in the past year? Yes No **If YES, how many?**______________

Pain: Please indicate your level of pain at this time by marking either the numerical or visual scale:

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Very Severe

NO HURT | HURTS LITTLE BIT | HURTS LITTLE MORE | HURTS EVEN MORE | HURTS WHOLE LOT | HURTS WORST

Please mark on the diagram above where you are having your symptoms/pain

To be completed by therapist:

Height:____________

Weight____________