ORTHOPEDIC ASSOCIATES
THERAPY CENTER

NAME: _____

Past Medical History

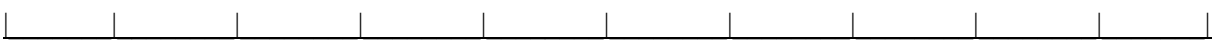
Height: _____ inches Weight: _____ lbs.

Medications (prescription and over-the-counter)

Medication Name	Dosage	Frequency	Route

*** You may also provide a previously compiled list ***

Pain



0 1 2 3 4 5 6 7 8 9 10

No Pain Slight Pain Minimal Pain Moderate Pain Significant Pain Severe Pain

During the last month, have you often been bothered by feeling down, depressed or hopeless? Yes No

During the last month, have you often been bothered by having little interest or pleasure in doing things? Yes No

In your home, do you feel safe and are you able to make phone calls, use your computer, and access your mail as you desire? Yes No

Do you currently smoke? Yes No

Falls

Have you fallen within the past year? Yes No If so, how many times? _____

If you have fallen, did it result in an injury? Yes No Injury: _____