ORTHOPEDIC ASSOCIATES
THERAPY CENTER

**NAME:** _____

**Past Medical History**

Height: _____ inches  Weight: _____ lbs.

Medications (prescription and over-the-counter)

| Medication Name | Dosage | Frequency | Route |
|---|---|---|---|
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*** 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

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: _____