| kintsugi PHYSICAL THERAPY & WELLNESS | **FALL PREVENTION INTIAL QUESTIONAIRE AND MEDICAL HISTORY** | Name:<br>Age:<br>Date: |
|---|---|---|

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|---|---|---|---|
| Your Medical Provider referred you to Physical Therapy because you reported a recent fall or they feel you have difficulty walking and are at risk for falls. Please answer the questions below to the best of your ability. | | | |
| Have you had a recent fall? | YES. Date of fall _____<br>No (if you have not had a recent fall, skip to the question with ***) | | |
| Where did you fall occur? | | | |
| What caused you to fall? | | | |
| Were you able to get up on your own after the fall? | YES NO | | |
| Were you injured in the fall? | YES. Please describe the injury: | | NO |
| Was 911 called? | YES NO | | |
| ***Do you experience dizziness? | YES NO | | |
| Do you use an ambulation aide? | YES NO. If YES, circle which of the following devices you use. | | |
| Single point cane | Quad scooter | Four wheeled scooter | |
| Front wheeled walker | Scooter | Wheelchair | |
| How long or how far can you walk? | | | |
| Do you walk on a regular basis? | YES NO | | |
| Do you have any difficulty walking on uneven surfaces? | YES NO | | |
| Do you have any difficulty walking up or down stairs? | YES NO | | |
| Do you need a handrail when using stairs? | YES NO | | |
| Do you have any difficulty or require and assistance with the below activities? | | | |
| Turning in bed | Sitting up | Getting in/out of bed | |
| Getting up from toilet | Standing up | Getting in/out of car | |
| Do you live in a: | House Apartment Assisted Living Facility Other (please specify): | | |
| Do live: | Alone With some (please specify): | | |
| Please indicate if you require assistance with any of the following activities. Circle all that apply. | | | |
| Bathing/showering | Dressing | Grooming | Eating |
| Please indicate if your place of residence has any of the following equipment | | | |
| Bedside commode | Rails/grab bars in shower/bathroom | Raised toilet seat | |
| Shower chair | Slide board for transfers | | |
| Date of most recent eye exam: | | | |
| Are you experience any pain anywhere? If yes please rate you pain on a scale of 0-10. 0 = no pain, 10 = emergency | NO YES:_____/10<br>Location: | | |
| Have you experienced any of the below symptoms recently? Circle all that apply. | | | |
| Abdominal pain | Dizziness/Lightheadedness | Hear burn / indigestion | Persistent cough |
| Bowel/Bladder changes | Fainting | Muscle weakness | Recent infection |
| Difficulty swallowing | Fever/Chills/Sweats | Nausea/Vomiting | Unexplained weight loss |
| Difficulty walking | Headaches | Night pain | Vision changes |
| What would you like to achieve from therapy? | | | |

**PLEASE COMPLETE THE OTHER SIDE**

| WORK HISTORY | | | |
|---|---|---|---|
| Are you currently employed? | YES NO. Retired. Student | | |
| Occupation: | | | |
| If injured on the job or with is affected by your current symptoms, please fill out the next three sections. | | | |
| Are you currently working? | YES/Full duty. YES/Light duty. NO/Last day of duty | | |
| Are you planning to return to your job of injury? | YES NO. Unsure | | |
| If no, has an alternate job goal been identified for you? | NO/I don't know<br>Yes, the new goal is: | | |
| MEDICAL HISTORY | | | |
| At the present time, would you say that your health is: | Excellent Good Fair Poor | | |
| Please indicate if you have had any prior injuries to the following joints. Circle all that apply. | | | |
| Ankle Back Elbow Foot Hand Hip Knee Neck Shoulder | | | |
| Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply. | | | |
| Allergies | Face/Ear/Jaw pain | Kidney disease | Pregnant (currently) |
| Anemia | Fibromyalgia | Latex of tape allergy | Rheumatoid arthritis |
| Asthma | Gout | Liver disease | Shortness of breath |
| Back/Neck pain | Heart Disease | Migraines | Skin Condition |
| Blood clots | Hepatitis | Multiple Sclerosis | Stroke / TIA |
| Cancer | Hernia | Osteoarthritis | Swelling in the feet /legs |
| Chest pain | Hight blood pressure | Osteoporosis | Thyroid issues |
| Depression | HIV+/AIDs | Pacemaker | Tuberculosis |
| Diabetes | Imbalance | Parkinson's | |
| Epilepsy / Seizures | Incontinence | Polio | |
| Please list and other medical conditions we should know about: | | | |
| Please list and surgeries you have had: | | | |
| Have you had any major illnesses/hospitalizations in the last year? YES NO If yes, please describe below: | | | |
| MEDICATIONS: Please list all medications you are taking including dosage, frequency, and route to administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability, If you have a list, please give it tour of front office so that they may make a copy.<br>[ ] Please see attached list. [ ] I am not taking any medications, vitamins, or supplements. | | | |
| Name | Dosage | Frequency | Route of Administration |
| | | 1 2 3 4x/day PRN | Oral Injection Other |
| | | 1 2 3 4x/day PRN | |
| | | 1 2 3 4x/day PRN | |
| | | 1 2 3 4x/day PRN | |
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| | | 1 2 3 4x/day PRN | |
| Have you had any falls in the last 12 months? | | YES NO | |
| If yes, how many? | | Did you injure yourself in any of those falls? | YES NO |
| Do you currently use any type of tobacco products? | | | |

_____ _____

Patient or Guardian Signature Date

For office use only: Heart rate_____ Blood Pressure_____ Taken by:_____