PATIENT NAME____________________________ TODAY'S DATE_________________

DATE OF BIRTH __________________ Height____ft____in Weight__________lbs

Have you had 2 or more falls, or any fall with an injury in the last 12 months? NO ☐ YES ☐

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Please list all of your medications including over-the-counter herbals & vitamin/mineral dietary (nutritional) supplements. Include dosage, frequency & route of administration.

MEDICATIONS AND SUPPLEMENTS	DOSAGE	FREQUENCY	

Please list any medical allergies you have such as medications, tape, etc.

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Discussed & reviewed with patient_____________________________
Physical Therapist's signature

*** BMI measure**☐ **PT initial** **Patient educated re: BMI** ☐ **PT initials**

*Vitamin D and Fall Risk correlation discussed with the patient. ☐PT initial

*Plan of care must include: consideration of Vit D supplementation AND balance, strength, and gait training. (0518F)