SPINESCOTTSDALE
PHYSICAL THERAPY

SPINEOSTEOPOROSIS/BALANCE/VERTIGO
PATIENT PRE-ASSESSMENT FORM

Name: _____ Date of Birth: _____Today's Date: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

SpineScottsdale Physical Therapy will use your e-mail to send newsletters, appointment reminders, and other physical therapy related information. If you do not give your permission for this e-mail correspondence, please indicate on the E-mail Address line above.

Emergency Contact: _____ Phone Number: _____

How did you choose SpineScottsdale Physical Therapy? _____

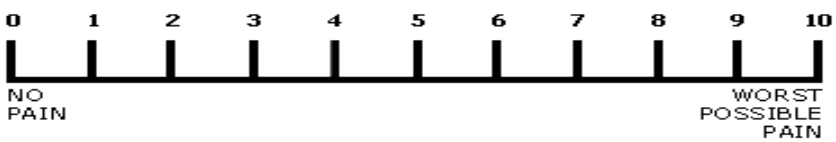
Referring Physician: _____ Primary Care Physician: _____

Do you have a follow up appointment with your referring physician? No:_____, Yes: _____(date)_____

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			**Why it matters**
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who may have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

Intensity of your symptoms: On a scale of 0 to 10, 0 meaning no pain and 10 meaning worst possible pain please circle the number that best describes your symptoms:



H:

W:

10277 N. 92nd St., Suite 103, Scottsdale, AZ 85258
Ph: (480) 584-3334 Fax: (480) 272-9369
www.spinescottsdale.com

SCREEN FOR SARCOPENIA

COMPONENT	QUESTION	SCORING
Strength	How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 Some = 1 A lot or unable = 2
Assistance in walking	How much difficulty do you have walking across a room?	None = 0 Some = 1 A lot, use aids, or unable = 2
Rise from a chair	How much difficulty do you have transferring from a chair or bed?	None = 0 Some = 1 A lot or unable without help = 2
Climb stairs	How much difficulty do you have climbing a flight of 10 stairs?	None = 0 Some = 1 A lot or unable = 2
Falls	How many times have you fallen in the past year?	None = 0 1 -3 falls = 1 4 or more falls = 2

MEDICAL HISTORY

Any unexplained night pain: Yes No

Any unexplained weight loss: Yes No

Please list any recent or major orthopedic surgeries with dates:

1._____ 2._____

Is there a possibility you are pregnant? Yes No

Do you currently have or have you had in the past any of the following?

Cardiac/Heart Problems	Yes	No	Severe Diabetes	Yes	No	Severe Migraines	Yes	No
Pacemaker/Defibrillator	Yes	No	Spine Fusion	Yes	No	Acute Inflammation	Yes	No
Cardiac Arrhythmia	Yes	No	Seizures	Yes	No	Spinal Stimulator	Yes	No
Thrombosis/Blood Clots	Yes	No	Kidney Stones	Yes	No	Pulmonary Embolism	Yes	No
Hip/Knee Replacement	Yes	No	Cancer (currently)	Yes	No	Epilepsy	Yes	No

Is there anything else we should know? ____ No _____Yes: _____

Please circle the following that apply to you: I play golf I have a desk job I want to join a fitness facility

I understand that I am responsible to inform the physical therapist of any health problems and allergies I have, as well as any drugs or medications I am taking. I further understand that I am responsible to inform the physical therapist of any changes in your medical status during the course of treatment.

Patient Signature: _____ Printed Name: _____ Date: _____

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MEDICATION/ SUPPLEMENT LIST

This form is a requirement of Medicare clinics effective 1/1/2019 for ALL patients, including non-Medicare patients. Please fill out all sections in their entirety.

Please include ALL medications, including

- Prescriptions
- Over-the-Counter
- Herbals
- Vitamins/ Mineral Supplements
- Nutritional/ Dietary Supplements

Administration Routes may include (but not limited to):

- Oral
- Sublingual
- Topical
- Subcutaneous

☐ I am currently not taking any medications.
☐ I have provided a full list of medications below:

Medication Name	Dose	Frequency	Administration Route

Patient Signature Printed Name Date
*Signature from parent is patient is a minor

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