

Lucia Miller Pelvic Health Physical Therapy

Physical Therapy and Pilates

EXTRA PATIENT INFORMATION

Patient Name: _____

Date: _____

	For the Patient	For the PT
BMI	Weight: _____ Height: _____	BMI Score: _____
Falls Risk	Have you had 2 or more falls in the past year? _____ Have you had a fall with injury in the past year? _____	Falls Assessment Complete? N/A _____ Yes _____ No _____ Falls Plan? N/A _____ Yes _____ No _____
Diabetes	Do you have a diagnosis of diabetes? _____	Plan? _____
Medications	Which Medications do you take, and at what dosage? _____	Medications Recorded? _____
Pain Level	Over the past 24 hours, what has your pain level been on a scale of 1- 10? _____	_____
Functional Survey(s)	Have you completed your functional survey(s)? _____	Score: _____
Additional Information:	_____	_____