



Name: _____ Date of Birth: _____ Referring MD: _____ Date: _____

Please check the following conditions as they apply to you:			
Conditions	Yes	No	Explain
Blood Disorders			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Hepatitis			
Kidney Disease			
Lymphedema			
Osteoarthritis			
Osteoporosis			
Pacemaker			
Rheumatoid Arthritis			
Stroke			
TB			
OTHERS (please specify) (i.e. MS, Parkinson's, Incontinence, etc.):			

1. Current complaint (include specific location of your pain with pain description):			
Please rate the severity of your pain by circling a number below			
No Pain	0	1	2 3 4 5 6 7 8 9 10 Unbearable pain
2. Diagnostic Testing (i.e. X-rays, MRI, CT Scan)? _____			
3. Are you currently taking any medications? Y _____ N _____			
If yes, please list: _____			
4. Falls in the past year? 0 falls 1 fall without injury 2+falls or 1 fall with Injury			
If 2+ falls, please explain: _____			
Patient Signature: _____ Date: _____			



Functional Assessment

Patient Use Only

Name: _____
 Phone: _____
 D.O.B.: _____
 Physician: _____
 Job Title: _____
 Diagnosis: _____

Date of Service

Have you had any falls in the past year? Yes No
 Do you exercise? No Yes
 If yes, please explain: _____
 Do you use an assistive device (i.e. cane): _____

What percentage of your week is spent performing the following task:

Task	Do you perform these activities?		Check categories you do not feel 100% confident completing due to injury.
	No	Yes	
Walking a dog or pushing a child in a stroller	No	Yes	
Unpacking groceries	No	Yes	
Climbing stairs	No	Yes	
Carrying a child	No	Yes	
Getting in and out of car	No	Yes	
Sweeping or vacuuming	No	Yes	
Taking out the garbage	No	Yes	
Loading/unloading dishwasher, washer, dryer	No	Yes	
Dusting overhead or below knee level	No	Yes	
Cooking/Baking	No	Yes	

Clinician Use Only

Physical Therapist
 Name: _____
 Physical Therapist Assistant: _____

LE balance/functional checklist

Functional Assessment

Ambulates 20 feet in < or = to 5.5 seconds
 Pivot turns in < or = 3 seconds
 Steps over a 6" obstacle without loss of balance or change in gait speed
 Ambulates 20 feet while turning head left or right every 5 feet without deviating > 12 inches or changing gait speed
 Ambulates 20 feet while tipping head up or down every 5 feet without deviating > 12 inches or changing gait speed
 Able to stand on one leg for > or = 5 seconds (time required to don pants in standing)
 Has functional reach of 10" or more
 Ambulates 10 steps heel to toe without loss of balance

Able/Unable

Home assessment needed? Yes No
Balance assessment needed? Yes No **LE functional assessment needed?** Yes No
BPPV assessment needed? Yes No Clinic: CL FL GL KN KS PL
Follow Up Date: Phone Fax E-mail PP RN RS TL UG WF

Comments: _____

