Name: ______________________________ **Date of Birth**: _____________ **Date:** ____________________

Email: ________________________________ **Preferred Pronouns:** _________ **Phone:** ____________________

Emergency Contact (name, phone number, relationship): ____

Medical History

List all medications (prescription & non-prescription): ____

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List all allergies: ____

Have you had a fall in the past year? (circle) YES NO

Do you now or have you ever had any of the following? Please include all history:

__ Coronary Heart Disease
__ Pacemaker
__ Shortness of breath
__ High/low blood pressure
__ Stroke/TIA/Blood clot
__ Chest pain (angina)
__ Heart attack
__ Congestive heart failure
__ Anemia
__ Pins or metal implants
__ Cancer
__ Hepatitis
__ Do you smoke?

__ Asthma/Bronchitis/Emphysema
__ Epilepsy or seizures
__ Thyroid disease
__ Diabetes
__ Gout
__ Osteoporosis
__ Bowel/bladder changes
__ Numbness or tingling
__ Vision/hearing problems
__ Arthritis
__ Dizziness
__ Are you pregnant?

__ Sleeping difficulty
__ Weakness
__ Unexplained weight loss
__ Fatigue
__ Depression/anxiety
__ Shoulder injury
__ Back injury
__ Elbow/hand injury
__ Knee injury
__ Neck injury
__ Foot/ankle injury
__ Hip injury

Surgical history (including year): ____

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____

Other: ____

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Patient/Guardian Signature: ____________________________________ **Date**: ______________________