



PATIENT NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____

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

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	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Discussed & reviewed with patient _____
Physical Therapist's signature

*Vitamin D and Fall Risk correlation discussed with the patient. PT initial
*Plan of care must include: consideration of Vitamin D supplementation as well as balance, strength, and gait training. (0518F)