Name _____

1	2	3	4	5	6	7	8	9	10

Please rate your pain by circling the appropriate number above where "0" is no pain at all and "10" is unbearable pain or pain that would send you to the ER.

Where is your pain located? _____

What is the frequency of your pain? Please circle one.

Infrequent Frequent Constant

Have you had any falls in the past 6 months? Yes or No

Do you experience dizziness when you stand after sitting or when you sit up after laying down?

Please list all your medications with strength and dosage:

_____

_____

_____

_____

Please list all surgeries with date performed:

			Date:
_____	**Hip**	**Right / Left / Both**	_____
_____	**Knee**	**Right / Left / Both**	_____
_____	**Shoulder**	**Right / Left / Both**	_____
_____	**Neck**		_____
_____	**Back**		_____
_____	**Other** _____		