REFORM PHYSICAL THERAPY
Don't neglect your health, reform it

Name:

DOB:

Date:

Have you fallen in the last year? **YES** **NO**

If YES, how many times have you fallen? ____

Do you worry about falling? **YES** **NO**

Do you feel unsteady standing or walking? **YES** **NO**

Have you received previous treatment? **YES** **NO**

If YES, please describe: ____

____

What kind of pain are you experiencing?

- Pain radiates down
- Tenderness
- Ache / Pain
- Pain radiates up
- Numbness / Tingling
- Other:

Please indicate effected region(s):

- Head / Neck
- Arm
- Pelvis
- Leg
- Upper Back
- Lower Back
- Shoulder
- Hand / Wrist
- Hip
- Knee
- Other: *(please describe)*

What aspects of life are affected by your pain?

____

____