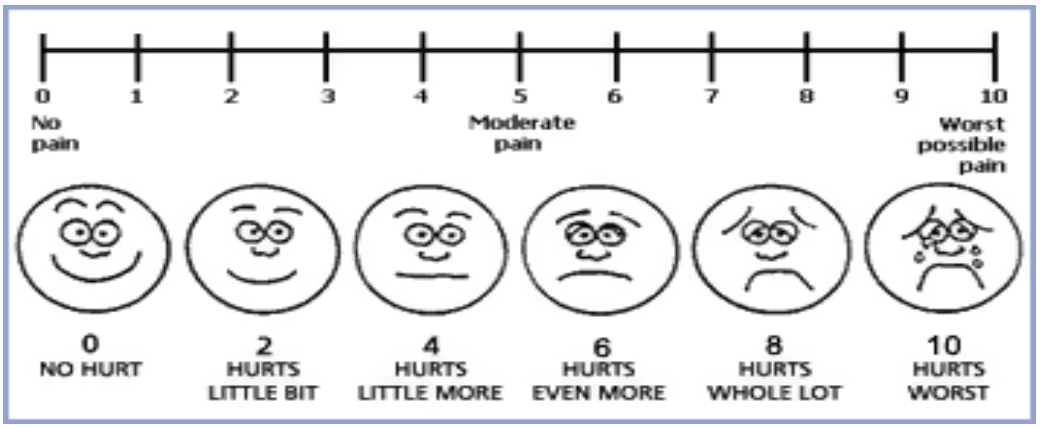
Patient Name:_____ Date:_____

Please list, or attach a list, of your current medications, including over the counter, supplements, and prescription:

Name	Dosage	Frequency	Route Administered
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please rate your current pain:



Have you had any falls in the past 12 months? □Yes □ No

If yes, how many? _____

If yes, how many falls with injury? _____

Please bring to your first appointment:

Completed New Patient Paperwork
Photo ID
Insurance Cards
Doctor Referral

*If applicable, please request your **medical imaging reports** and/or **operative reports** be faxed to our office prior to your first appointment. Fax: 707-935-8481