Dorner Physical Therapy

4200 Trabuco Road, Suite 180, Irvine, CA 92620 • Phone: (949) 651-9199 • Fax: (714) 730-1882

Patient Name:_____Date:_____

Please rate your pain over the past week on a scale of 0-10 with 0 being no pain and 10 being the worst pain you can imagine.

Best your pain can be: 0 1 2 3 4 5 6 7 8 9 10 (circle 1 number)

Worst your pain can be: 0 1 2 3 4 5 6 7 8 9 10 (circle 1 number)

Please list all medications (includes prescription, over-the-counter, herbals, vitamin/dietary, nutritional supplements)

Drug Name	*Dose*	*Frequency*	*Route*

3. Have you had any falls in the last 12 months? Yes or No

If yes, how many times _____

Were you injured from the fall(s)? Yes or No

For Office Use Only:

Wt_____ Ht_____ BMI_____ (Normal Under Over)