Name: ______________________ Date: __/__/___ Weight: _____lbs. Height: __' ___"

How is your general health?: Poor Fair Good Excellent

Please circle your activity level: Low Medium Active Highly Active

Falls in the last 6 months? ___ Yes ___ No

If yes, how many falls? ________

Hospital, ER, or Urgent Care visits in the last 6 months? ___ Yes ___ No

Related to the fall? ___ Yes ___ No

Please check all that apply:

- Your injury is a result of an accident from employment.
- Your injury is a result of an auto accident.
- Your injury is a result of any other type of accident.

Injury Date: ____/___/____ (if applicable) The state where injury occurred ________ (AZ, CA, WY, ECT...)

PATIENT NARRATIVE- Please explain the reason for your visit OR how the injury occurred:

____

____

____

Have you received this device or a similar brace within the past five years? ___ Yes ___ No

If marked Yes, please specify: ____

____

____

Do you have an Amputation? __ Yes __ No

Amputation Level:	Amputation Reason:	Amputation date:
__ Above Knee	__ Trauma	
__ Through Knee	__ Circulation	____/ ____/ _____
__ Below Knee	__ Born without Limb	
__ Through Ankle	__ Tumor	
__ Partial Foot	__ Infection	
__ Above Elbow	__ Other	
__ Below Elbow		

Do you have any allergies? Please specify:

____

____

____

Are you currently taking any pain medication? Please specify:

Name: ______________________

Dosage: ______________________

Frequency: ______________________

Have you had any major surgeries?

Surgery type: ______________________________

Year: __________

Do you have or have had any of the following conditions:

__ Alzheimer's or Dementia
__ Anxiety
__ Asthma
__ Brain Injury/TBI
__ Cancer
__ Depression
__ Diabetes Type 1
__ Diabetes Type 2
__ Hearing Loss
__ Heart Problems
__ Hepatitis
__ High Blood Pressure
__ HIV
__ Infections
__ Intestinal Problems
__ Kidney Disease
__ Liver Disease
__ Migraines
__ MRSA
__ Neurological Problems
__ Obesity
__ Osteoarthritis
__ Osteoporosis
__ Parkinson's Disease
__ Pulmonary Disease (TB)
__ Rheumatoid Arthritis
__ Seizure Disorders
__ Skin Problems
__ Stomach Problems
__ Stroke/TIA/CVA
__ Vascular Disease
__ Vision Problems

Other Conditions: ______________________________

Right Left Left Right

Front Back

Please circle or point to the area you are feeling pain.

On a scale of 1- 10 how bad is your pain?

1 2 3 4 5 6 7 8 9 10

Better **Worse**

Recent change in weight?

__ Yes __ No

__ Loss How Much ______ Lbs.

__ Gain