EAST TENNESSEE
SPINE & SPORT
PHYSICAL THERAPY

Please fill out all information requested below:

- **Patient Name:** _____
- **Height:** _____
- **Weight:** _____

- List all current medications below. If you are taking more than 6 medications, please provide a list to the administrative staff.

  - **Medication Table**

No:	Medication Name:	Dose:	Frequency:	Administration Route:* (circle one)	Type:*(circle one)
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____

***Description:** *Oral= Taken by mouth*
Topical= Applied to skin
RX= Prescribed by medical professional
OTC= Over the counter (ex: Advil)

- How many falls have you had in the last 12 months? (Circle One): 0 1 >2

Patient Signature: _____

Witness: _____ Date: _____