EAST TENNESSEE
SPINE & SPORT
PHYSICAL THERAPY

Please fill out all information requested below:

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

- **How many falls have you had in the last 12 months? (Circle One): 0 1 >2**
- **Do you currently use tobacco products? (Circle one): YES NO**
- **List all current medications below. If you are taking more than 6 medications, please provide a list to the administrative staff.**

Medication Table

#:	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)

Emergency Contact: _____ Relation: _____
Contact Number: _____

Patient Signature: _____ Date: _____

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Witness: _____