GREENCASTLE
PHYSICAL THERAPY & SPORTS MEDICINE

Name:_____

Medicare now requires that we obtain a full list of your medications including ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications' name, dosage, frequency and route of administration. Please list below or provide a complete separate list.

Medications' Name	**Dosage**	**Frequency**	**Route of Administration (Orally, Topically, Injection, etc.)**

We are also required to document your fall risk.

Please check the appropriate choice

____ In the past year I have fallen 2 or more times **OR** have fallen and injured myself

____ In the past year I have fallen only once without injury **OR** have not fallen at all

Signature:_____ Date:_____