Name:____

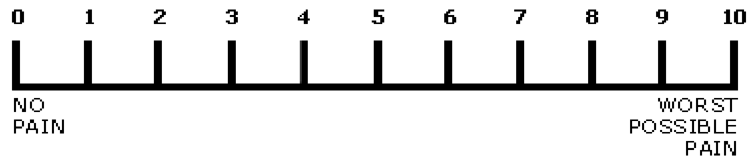
Date pain / discomfort began:____

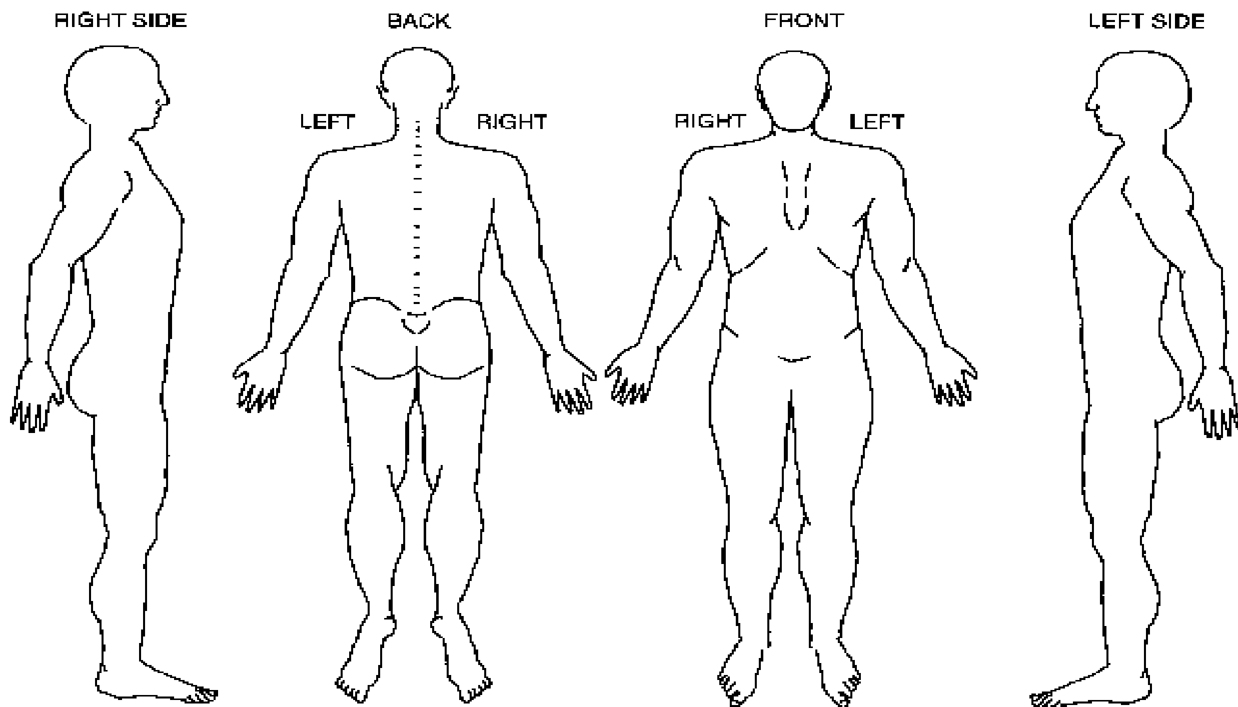
Date of surgery (if surgery was performed):_______________________

Height:__________________ Weight:__________________________

Please mark an **"X"** over the areas of your discomfort/pain, then circle the number on the scale for how you would rate your discomfort/pain (0 to 10).

0-10 Numeric Pain Intensity Scale





Have you fallen 2 or more times in the past 2 years **WITH injury**? Yes or No

Have you had 1 fall or **NO falls** in the past year with **NO injury**? Yes or No

I have not fallen in the past 2 years. _________ (please initial)