BIG PHYSICAL THERAPY

Objective Measure Questionnaire

Please answer the following questions as accurately as possible for the required insurance reporting

NAME:_____ Date:_____

1. **Height**:_____Feet_____Inches **Weight**:_____

2. Have you had any **falls** over the past year? _____Yes _____No

   If so, how many? _____

   Were you injured during any of the reported falls? _____Yes _____No

3. Please write or give a copy of your current **medications**, prescribed and over the counter:

Thank you for your assistance!

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