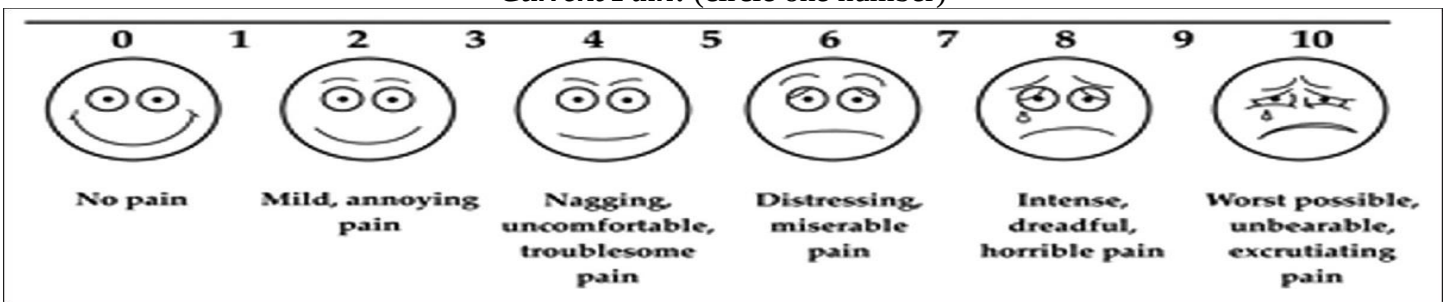
Asheville Physical Therapy
Orthopedics • Sports Medicine • Sports Performance

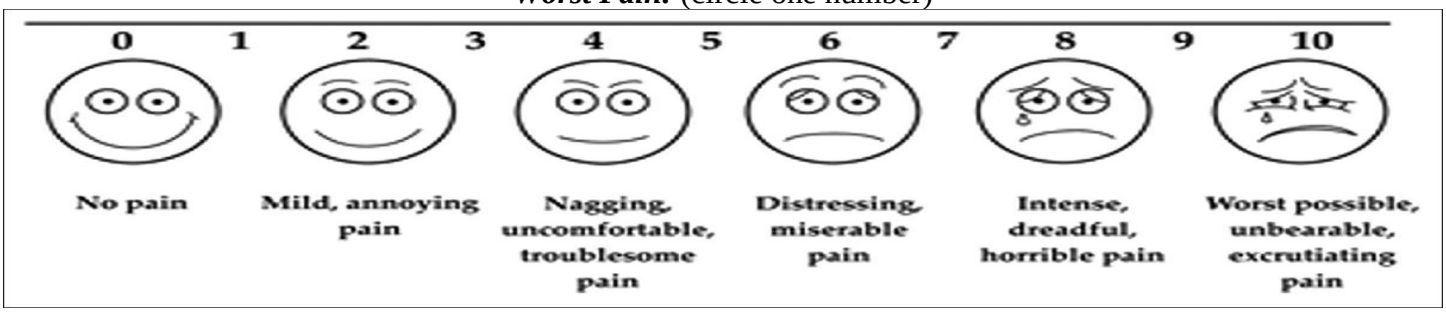
76 Peachtree Rd, Suite 204 · Asheville, NC 28803 · Phone 828·277·7547 · Fax 828·277·7540

Patient's Name: _____ Weight: _____ Height: _____
Primary Care Physician_____
Have you had any falls? Yes or No When: _____

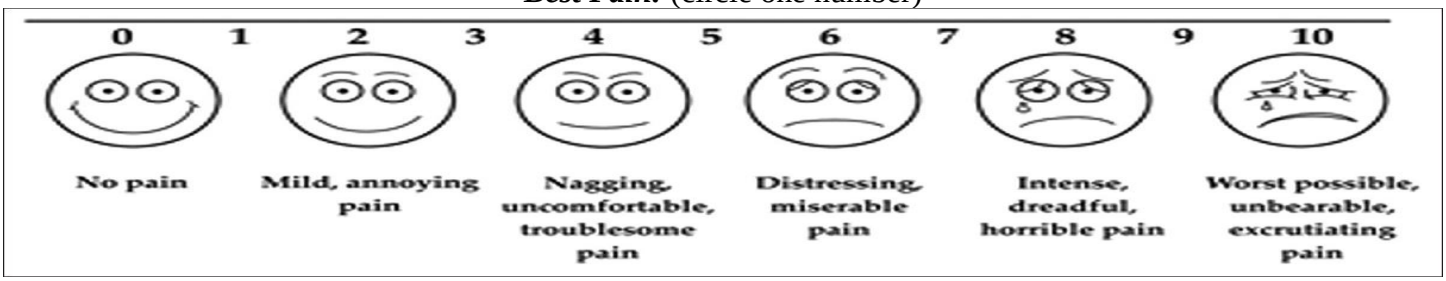
***Current Pain*:** (circle one number)



Worst Pain: (circle one number)



Best Pain: (circle one number)



Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements, and the dosage, frequency and administration method By my signature below, I certify that the information I have provided above and/or on a separate document is complete, accurate and truthful to the best of my knowledge.

Medication	Dosage	Frequency (Once daily, Twice daily, Three times daily, As needed, Other)	Method of Administration (Oral, Sublingual, Topical, Subcutaneous, Injection, Other)

By my signature below, I certify that the information I have provided above and/or on a separate document is complete, accurate and honest l to the best of my knowledge
Patient/Legal Guardian Name: _____/Legal Guardian Signature: _____ Date _____