



FALL PREVENTION GROUP MEDICAL VISIT

3706 Ruffin Road, Suite 129, San Diego, CA 92123

Phone: 858-587-1822 | Fax: 858-587-8967

FEE PER MEDICAL VISIT

\$147.00 Medicare patients call for reduced pricing. Fee will be collected at time of service and will be billed to insurance for direct reimbursement to patient.

REQUIREMENTS

All equipment will be provided. Please bring a towel if desired.

REGISTRATION

Name _____ Gender Male Female

Date of Birth _____

Email _____

Phone _____

Class: 10:00-11:00 am (Tuesday & Thursday each week)

WAIVER APPROVAL

In consideration of accepting entry, I, the below signed intending to be legally bound for myself, my heirs, my executors and administrators, waive and release any and all rights and claims for damages I may have against the physician, the medical center, and the representatives, successors and assigns for any injury suffered by me in the said event. I attest that I will participate in the group medical visits, that I am able to meet the physical requirements stated for activity. I agree that in registering for this course I am obligated to pay for the full program and that any missed appointments are my financial responsibility. Furthermore, I hereby grant full permission to use my name and likeness, as well as any photographs and any record of this event which I may appear for legitimate purpose, including advertising and promotion.

Signature: _____ Date: _____

FALL PREVENTION QUESTIONNAIRE

DEMOGRAPHIC

Name _____ Age _____ Gender Male Female

HISTORY

Number of falls in the past 3 months: 0 1-3 4-6 >6

Assistance Device for gait: None Cane Walker Other _____

Location of Pain: Back Neck Hip Knee Ankle Shoulder Elbow Wrist Head

Severity of Pain: 0 1 2 3 4 5 6 7 8 9 10

Duration of Pain: < 6 Month > 6 Months >1 Year >5 Years Other _____

SYMPTOMS

Vision: Restricted Vision Blurry Vision Double Vision

Cardiovascular: Chest Pain Palpitations Shortness of Breath

Neurological: Weakness Dizziness Loss of Sensation Poor Balance

Joint Pain: Hip Knee Ankle Shoulder Elbow Wrist

PHYSICAL LIMITATIONS

Past Orthopedic Surgeries

Joint replacement

Hip Knee Ankle Shoulder Elbow Wrist None

Spinal Fusion

Back Neck Sacrum None

Known Disease

Heart Disease Cancer Diabetes

Mail, Fax, or Phone to confirm Registration.

This form must be completed in order to enroll.

FALL PREVENTION SCHEDULE

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**All visits will be held on Tuesday and Thursday in 2018
according to the following schedule.**

10:00 am visits offered.

AUGUST – SEPTEMBER 2018

Aug. 14, 16, 21, 23, 28, 30 Sept. 4, 6, 11, 13, 18, 20, 25, 27

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