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 QUESTIONAIRE

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.