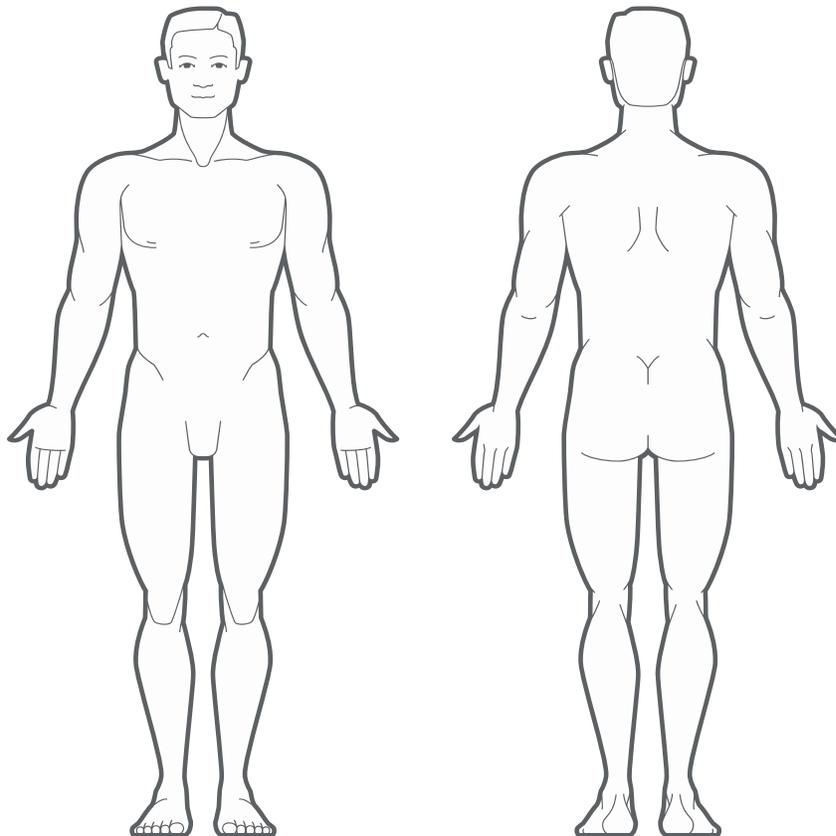


Body Diagram

Name _____

Date _____

Please mark the area(s) on this diagram where you are experiencing your symptoms.



Learning Preference

What is your learning preference? Verbal Written Demonstration

Fall Screening:

Have you had any falls in the past year? Yes No

If yes, how many: 1 2 3 4 5+

Why? _____

Do you feel unsteady when standing or walking? Yes No

Do you worry about, or have a fear of, falling? Yes No