NEW PATIENT FORMS

PATIENT DEMOGRAPHICS

Name _____ DOB _____ /_____ /_____

Street Address _____

City _____ State _____ GA _____

Phone _____-_____-_____ Insurance _____ ID# _____

DIABETES MANAGEMENT ASSESSMENT

Are you diabetic? _____ Yes _____ No

Do you take insulin? _____ Yes _____ No

Do you test your blood sugar? _____ Yes _____ No

How many times per day? _____

Are your fingertips sore and bruised? _____ Yes _____ No

Would you like information on our diabetes meal delivery service? _____ Yes _____ No

FALL RISK ASSESSMENT

Are you afraid of falling? _____ Yes _____ No

Have you fallen recently? _____ Yes _____ No

Do you experience dizziness? _____ Yes _____ No

Do you take 4 or more prescription medications daily? _____ Yes _____ No

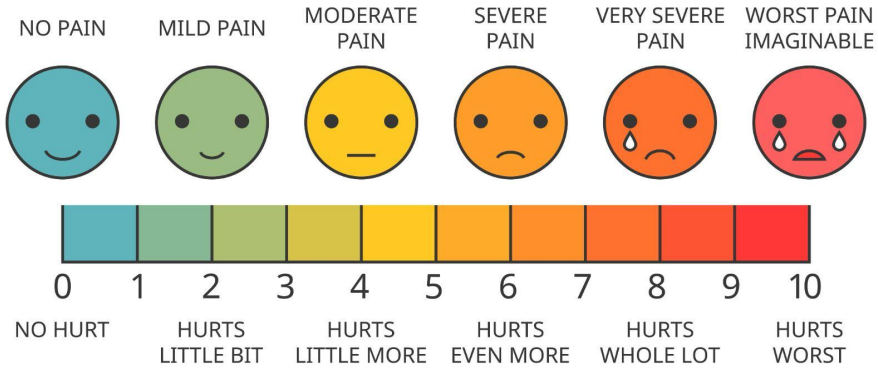
Are you interested in improving your balance or mobility? _____ Yes _____ No

PAIN ASSESSMENT

Do you have pain or arthritis in any of the following areas?

If so, please indicate the level of pain you experience by using the pain faces scale below:

Hands _____ Feet _____ Knees _____ Back _____ Fingers _____ Shoulder _____



*If you have questions about completing this form, please contact our office at **(678) 919-9128.**