

**Patient**\_\_\_\_\_

**Date**\_\_\_\_\_

Have you received any type of home health services in the past 3 months?

Yes

No

If so, which company provided the services?

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How many times have you fallen in the past year? \_\_\_\_\_

Did any of those falls result in an injury? \_\_\_\_\_

To be completed by BRPT staff:

Current Height\_\_\_\_\_

Current Weight\_\_\_\_\_