\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name

Senior Adult Intake – please complete if you are over 65 years old, or if you have concerns about the topics listed below.

Do you have a medical Durable Power of Attorney for Healthcare? ⬜ No ⬜ Yes

(If yes please bring a copy) Name/Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will? ⬜ No ⬜ Yes (If yes, please bring a copy)



Are you afraid of falling? ⬜ Yes ⬜ No

Have you had a fall in the past year? ⬜ Yes ⬜ No

If yes, please tell us about your last fall:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did this fall happen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you need to see a doctor or other professional for treatment after this fall? ⬜ Yes ⬜ No

Do you use a walking aid such as a cane or walker (circle one) ⬜ Yes ⬜ No

Do you drive? ⬜ Yes ⬜ No