
# *Center for Balance, Gait & Fall Prevention*

## *HVCPA Gait Analysis Lab Registration Form*

*15 Mt Ebo Road South; Brewster, NY*
(P) 845/ 878-9078

Please fill in the registration form prior to your Gait Analysis. The information provided will only be used for identification purposes of your Gait Analysis Report and communication with your physician.

Name_____ Gender: _____

Address_____ Apt____ City_____ State_____ Zip_____

Home Phone #_____ Work Phone #_____ e-mail_____

Birth date _____/____/____ Age_____ Marital Status: M S W D # Children_____

Height: _____ Weight: _____ How long at this weight?_____

Occupation/Former Occupation_____

Spouse's Name_____ Spouse's Work #_____

Referred By:_____Nearest Relative & Phone #_____

**HEALTH INFORMATION**

What is your major complaint? Why are you here? _____

_____

How long have you had this present issue? _____

If you have fallen, in your opinion is this condition getting progressively worse?_____
In the past **6 months** have you fallen (please check): none ☐ 1-3 times ☐ More than 3 times

Has anyone indicated to you, or do you know why you are having these issues? _____

Other doctors/professionals/hospitals who have treated this condition: _____

_____

List surgeries/operations/procedures_____

_____

_____

Please List the Names of Drugs you now take **(if you need more space, please use other side**):

1._____2._____
3._____4._____
5._____6._____
7._____8._____

Please list other medical/health issues you have had in the past, or are currently experiencing: Items can include, but not limited to, Parkinson, Low back issues, cancer, neck and shoulder issues, fatigue, dizziness, etc. _____
_____
_____
_____

Do you feel safe in your home?_____

Does your home have: Please check all that applies.

- ☐ Throw rugs? ☐ Is carpeting on steps loose or worn? ☐ Are handrails loose or broken?
- ☐ Step stools that are unsteady? ☐ Do you have supports in your tub or near your toilet?
- ☐ Is your path from the bed to your bathroom clear of clutter? ☐ Is your path well lit?

Do you wear: ☐ Orthotics ☐ Heel lifts ☐ Arch supports ☐ Inner soles

Do you have a hearing loss?_____When did you last have your hearing checked?_____

Do you wear glasses?_____ If so, why do you wear glasses? Ie. reading, distance. etc: _____
_____

When was your last "eye" checkup? _____

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never
Describe:_____

**Name of your Primary Care Physician (PCP**)_____

Address:_____

City_____ State_____ Zip _____

Tel#_____

Date of your last completed physical exam:_____

**Your Signature and today's date:**

**X**_____ **X**_____
**Your Signature** **Date:**