MIPS

Patient Name: _____

Date: _____

	For the Patient	For the PT
BMI	Weight: Height:	BMI Score:
Falls Risk	Have you had 2 or more falls in the past year? _____ Have you had a fall with injury in the past year? _____	Falls Assessment Complete? N/A____ Yes ____ No_____ Falls Plan? N/A____ Yes ____ No_____
Diabetes	Do you have a diagnosis of diabetes? _____	Plan?
Medications	Which Medications do you take, and at what dosage?	Medications Recorded?
Pain Level	Over the past 24 hours, what has your pain level been on a scale of 1-10?	
Functional Survey(s)	Have you completed your functional survey(s)?	Score:
Additional Information:		