### Home Environment

**How would you rate your health?**
- [ ] excellent
- [ ] good
- [ ] fair
- [ ] poor

**Do you exercise regularly?**
- [ ] does
- [ ] does not

**How many falls have you had in the past 6 months?**
- [ ] 0
- [ ] 1 to 2
- [ ] >3

**What is your employment status?**
- [ ] employed
- [ ] unemployed
- [ ] retired

If yes, what do you do for a living?

**Do you live alone?**
- [ ] alone
- [ ] with someone

**Do you require assistance at home?**
- [ ] Yes
- [ ] No

**Do you have stairs at home?**
- [ ] Yes
- [ ] No

If yes, how many?
- [ ] 1-8
- [ ] 9-15
- [ ] >15

Where is the railing as you go up the stairs? (Select all that apply)
- [ ] left
- [ ] right

### Goals/Followup

**What are your goals for therapy?**

**When are you scheduled to return to the doctor for follow-up?**
- [ ] as needed
- [ ] within 1 month
- [ ] after completion of therapy

**Additional Comments:**