

## **Balance Screening Registration & Consent Form**

Name:		Phone:				
Address:			City:	Zip:		
Gender: Da	te of Birth:/	/ Height:	Weight:	Email:		
Primary Physician:						
en, their employees, of action which are i scheduling and cost tions provided. I und	agents, volunteers, an n any way connected s of future medical eva erstand that this scree statistical and education	d other persons actin to my participation in aluation, diagnostic te ning is not intended t	g in any capacity or this screening. I acc ests and treatment i o be a complete bala	Screening. I agree to voluntaril their behalf, from any and all ept all responsibility for the e n addition to the pursuit of ar ince examination. McLaren ma eleased to any person or organ	claims or causes valuation, future by recommenda- by use the results	
Participant Signatu	re:			Date:		
If you have fallen in the <b>Fall #1:</b> (a) Date: (b) Location (e.g., E	have you fallen within past 12 months, please Bathroom, garden, gro e.g., uneven surface, g	provide a detailed descr  cery store):	iption of 1or 2 inciden			
		e	,.			
	Bathroom, garden, gro					
(c) Reason for fall (	e.g., uneven surface, g	oing downstairs):				
	<b>you about falling?</b> 456 Moderately					
2. In the past 4 wee household chores	ks, to what extent did 5)?		nit your everyday	o <mark>hysical activities (such as w</mark> a y (5)	alking and	
Yes No	require household o	-				
breathing, heart	participate in regula rate, or perspiration? ays per week? One	Yes No		ugh to cause a noticeable in	crease in	
	vould you rate the qu		0 10			
Very Low Lo	456 w Moderate		Very High			