Name: _____ **Date:** _____

Verbal Descriptor Scale

Instructions: Please place a check mark next to the phrase that best describes your current pain level.

_____ Most Intense Pain Imaginable

_____ Extreme Pain

_____ Severe Pain

_____ Moderate Pain

_____ Mild Pain

_____ Slight Pain

_____ No Pain

Vaccine Status

Flu received? Yes Date: _____ No Declines Plan to Receive Unknown

Pneumococcal received? Yes Date: _____ No Declines Plan to Receive Unknown

Fall Assessment

Any falls in the past year? Yes No

Have you had **2** or more falls with **NO injury** in the past year? Yes No

Have you had at least **1** fall **WITH an injury** in the past year? Yes No