Do not write, stamp, punch holes or affix a sticker in this area.

Fall Risk

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Have you had a fall in the last year?	Yes ○ No ○
Have you had 2 or more falls in the last year?	Yes ○ No ○
In the last year, have you had a fall that resulted in injury?	Yes ○ No ○
Have you been advised to use a cane or a walker to ambulate safely?	Yes ○ No ○
Do you sometimes feel unsteady when walking or standing?	Yes ○ No ○
Do you hold onto furniture to steady yourself when walking at home?	Yes ○ No ○
Are you worried about falling?	Yes ○ No ○
Do you need to push with your hands to stand up from a chair?	Yes ○ No ○
Do you have some trouble stepping up onto a curb?	Yes ○ No ○
Do you often have to rush to the toilet?	Yes ○ No ○
Have you lost some feeling in your feet?	Yes ○ No ○
Does your medicine sometimes make you light-headed or more tired than usual?	Yes ○ No ○
Do you often feel sad or depressed?	Yes ○ No ○