Modified Falls Risk Checklist

Patient: ______________________ Date: ______________ Time: __________ AM/PM

Directions: Please answer Yes or No to each of the presented questions.

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
Have you had any falls in the past year?	☐ Yes ☐ No	
Did you sustain an injury during the fall?	☐ Yes ☐ No	
Do you worry about falling or feel unsteady when standing/walking?	☐ Yes ☐ No	
Vision		
Is your visual acuity less than 20/40?	☐ Yes ☐ No	
Have you had an eye exam in the past year?	☐ Yes ☐ No	

BOTTOM SECTION TO BE FILLED OUT BY PHYSICAL THERAPIST

Fall Risk Factor Identified	Factor Present?	Notes
Gait, Strength, & Balance		
Is Timed Up and Go (TUG) Test ≥ 12 seconds?	☐ Yes ☐ No	
Is 30-Second Chair Stand Test below average score?	☐ Yes ☐ No	
Is 4-Stage Balance Test Full tandem stance ≤ 10 seconds?	☐ Yes ☐ No	
Postural Hypotension		
Is there a decrease in systolic BP ≥ 20 mm Hg or a diastolic BP of ≥ 10 mm Hg from lying to standing?	☐ Yes ☐ No	
Is there lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	