Associated Neurological Specialties

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Fall Risk ~ Self Assessment

Name:_____ Date:_____

Physician:_____ D.O.B.:_____

	YES	NO
Have you fallen in the past six months?	☐	☐
Do you have a fear of falling?	☐	☐
Does your fear of falling limit your activity level?	☐	☐
Are you taking four or more medications a day?	☐	☐
Do you suffer from dizzy spells or are you feel light-headed when you stand up?	☐	☐
Do you use an assistive device such as a cane or a walker when walking?	☐	☐
Do you have uncorrected visual impairments?	☐	☐
Do you have difficulty transferring from a sitting to standing position?	☐	☐
Does your home environment have loose area rugs, cords, and/or clutter?	☐	☐
Do you currently have any medical conditions that may contribute to falls such as diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Arthritis, Neuropathy, Other_____?	☐	☐

Yes = 1 No = 0 Total Score=_____

A TOTAL SCORE OF 4 OR MORE = HIGH RISK FOR FALLS