Building strength and mobility

Reboot

# BALANCE SELF TEST

## Are you at Risk for Falls ?

Name: _____ Date: _____

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|---|---|---|---|
| 1. | Have you fallen more than once in the past year? | Yes | No |
| 2. | Do you lose balance when standing still, or when you initially get up after sitting? | Yes | No |
| 3. | Does it take you more than one try to get out of a chair or bed? | Yes | No |
| 4. | Do you lose your balance or feel unsteady when walking? | Yes | No |
| 5. | Do you use a walker, cane, or need assistance getting around? | Yes | No |
| 6. | Have you had a recent loss or decrease in vision or hearing? | Yes | No |
| 7. | Do you have numbness or loss of sensation in your feet or legs? | Yes | No |
| 8. | Do you trip over your own feet or objects on the floor? | Yes | No |
| 9. | Do you take unnecessary risks (ie: standing on chairs or walking on slippery floors? | Yes | No |
| 10. | Do you take corners too sharp and bump into corners or door frames? | Yes | No |
| 11. | Do you get dizzy, faint, or have seizures? | Yes | No |
| 12. | Have you experienced a stroke or any other health problems that may have affected your balance? | Yes | No |

*If you answered YES to one or more questions ,you may have a balance problem. Consult with our physicla therapist about your questions and concerns. You may need balance and gait evaluation and training. Keep in mind your insurance covers these treatments with a prescription or a referral.*