Nature Coast Orthopaedics

Fall Risk Screening

Name: ______________________________________ DOB: ______________ Date: ______________

1. Have you fallen in the past 12 months? YES NO

   A. If yes, how many times have you fallen? ________________________________

   B. How did you fall? ____
   ____
   ____

   C. Did you injure yourself and, if so, what was the injury?
   ____
   ____
   ____

2. Can you stand up from a chair without using your arms? YES NO
3. Do you always feel steady when you stand or walk? YES NO
4. Can you balance on one leg? YES NO
5. Can you walk without a cane or other assistive device? YES NO
6. Do your shoes fit properly? YES NO
7. Can you see well without glasses or bifocals? YES NO
8. Can you hear well in a noisy room? YES NO
9. Do you feel you are as active as you would like to be? YES NO
10. Do you have a nightlight or lamp in your bedroom? YES NO
11. Have you removed all throw rugs in your home? YES NO