# Fall Risk Questionnaire

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