FALLS RISK CHECKLIST

ID NUMBER: | | | | | | | |

FORM CODE: | F | R | C |

DATE: 4/01/2016
Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

0b. Staff ID: ☐☐☐

Instructions: *Please select "Yes" or "No" for each statement below.*

1. I have fallen in the past year.
   - ☐ 2 Yes
   - ☐ 0 No
2. I use or have been advised to use a cane or walker to get around safely.
   - ☐ 2 Yes
   - ☐ 0 No
3. Sometimes I feel unsteady when I am walking.
   - ☐ 1 Yes
   - ☐ 0 No
4. I steady myself by holding onto furniture when walking at home.
   - ☐ 1 Yes
   - ☐ 0 No
5. I am worried about falling.
   - ☐ 1 Yes
   - ☐ 0 No
6. I need to push with my hands to stand up from a chair.
   - ☐ 1 Yes
   - ☐ 0 No

7. I have some trouble stepping up onto a curb.

   ☐ 1 Yes

   ☐ 0 No

8. I often have to rush to the toilet.

   ☐ 1 Yes

   ☐ 0 No

9. I have lost some feeling in my feet.

   ☐ 1 Yes

   ☐ 0 No

10. I take medicine that sometimes makes me feel light-headed or more tired than usual.

    ☐ 1 Yes

    ☐ 0 No

11. I take medicine to help me sleep or improve my mood.

    ☐ 1 Yes

    ☐ 0 No

12. I often feel sad or depressed.

    ☐ 1 Yes

    ☐ 0 No

13. Total = _____