Client Name ______________________________

Address ______________________________

City ______________ Postal Code __________

Health No. ______________ Date of Birth __________

FALL RISK QUESTIONNAIRE

Do you… DATE								
1. Fall?	Yes	No	Yes	No	Yes	No	Yes	No
2. Have frequent slips, trips or near falls?	Yes	No	Yes	No	Yes	No	Yes	No
3. Have a fear of falling?	Yes	No	Yes	No	Yes	No	Yes	No
4. Notice a recent unexpected change in your ability to function?	Yes	No	Yes	No	Yes	No	Yes	No
5. Have weak muscles or stiff joints?	Yes	No	Yes	No	Yes	No	Yes	No
6. Have difficulty keeping your balance?	Yes	No	Yes	No	Yes	No	Yes	No
7. Have foot problems?	Yes	No	Yes	No	Yes	No	Yes	No
8. Have a poor diet &/or limited fluid intake?	Yes	No	Yes	No	Yes	No	Yes	No
9. Ever feel dizzy?	Yes	No	Yes	No	Yes	No	Yes	No
10. Take seven or more medications?	Yes	No	Yes	No	Yes	No	Yes	No
11. Have vision problems?	Yes	No	Yes	No	Yes	No	Yes	No
12. Have hearing problems?	Yes	No	Yes	No	Yes	No	Yes	No
13. Experience shortness of breath?	Yes	No	Yes	No	Yes	No	Yes	No
14. Have to rush to the bathroom?	Yes	No	Yes	No	Yes	No	Yes	No
15. Have trouble sleeping?	Yes	No	Yes	No	Yes	No	Yes	No
16. Drink alcohol frequently?	Yes	No	Yes	No	Yes	No	Yes	No
17. Experience difficulties concentrating?	Yes	No	Yes	No	Yes	No	Yes	No
18. Neglect to regularly check for safety hazards in and around the home?	Yes	No	Yes	No	Yes	No	Yes	No
19. Walk in places that are uneven, slippery or icy?	Yes	No	Yes	No	Yes	No	Yes	No
Total "Yes" Score								
Initials of tester								

June 2015