ADVANCED PHYSICAL THERAPY OF VIRGINIA

Fall Risk Assessment

Name:

Date:

Questions:

1. Have you fallen in the past year?

◯ Yes ◯ No

2. Have you fallen more than once?

◯ Yes ◯ No

3. Have you been injured as a result of a fall?

◯ Yes ◯ No

4. Do you have difficulty rising from a chair?

◯ Yes ◯ No

5. Do you take narcotics for pain, high blood pressure meds, diuretics, blood thinners, or heart medications?

◯ Yes ◯ No

6. Do you feel dizzy when you get up from a bed or chair?

◯ Yes ◯ No

7. Do you have uncorrected vision problems (i.e. glaucoma, cataract(s), or blindness in half of your vision field)?

◯ Yes ◯ No

8. Are you over 65 years of age?

◯ Yes ◯ No

If you answered "Yes" to any two (2) of the above questions, you could be at risk for falling. Based on your responses and the therapist's evaluation, your risk for falling will be assessed. If you have any questions regarding this, please talk with your therapist.

What you can do to reduce your risk of falling:

- Wear non-skid shoes (tennis shoes, walking shoes)
- Avoid using throw rugs at home; use non-skid mesh carpet backing
- Install grab bars in your bathroom
- Use lighting at night
- Clear pathways of furniture

Patient Signature: _____

For Office Use Only:

Therapist Signature: _____

Blood Pressure _____