Robert M. Cain, MD

Fall Risk ~ Self Assessment

Name:_____ Date:_____

	YES	**NO**	LEAVE BLANK FOR DOCTOR'S USE
Have you fallen in the past six months?			
Do you have a fear of falling?			
Does your fear of falling limit your activity level?			
Are you taking four or more medications a day?			
Do you suffer from dizzy spells or are you feel light-headed when you stand up?			
Do you use an assistive device such as a cane or a walker when walking?			
Do you have uncorrected visual impairments?			
Do you have difficulty transferring from a sitting to standing position?			
Does your home environment have loose area rugs, cords, and/or clutter?			
Do you currently have any medical conditions that may contribute to falls such as diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Arthritis, Neuropathy, Other_____?			

Yes = 1 No = 0 Total Score=_____

A TOTAL SCORE OF 4 OR MORE = HIGH RISK FOR FALLS

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS