# Associated Neurological Specialties

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## Fall Risk ~ Self Assessment

Name:_______________________________________________ Date:_________________

Physician:____________________________________________ D.O.B.:________________

| | YES | NO |
|---|---|---|
| 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**