

Outpatient Therapy Services Fall Risk Assessment Screening Questions

Name: _____

Date: _____

Questions	Yes	No
1. Have you fallen in the past six (6) months?		
2. Do you have difficulty rising from a chair?		
3. Do you take ANY of the following prescription medications? Narcotics for pain; high blood pressure medications; diuretics (water pills); blood thinners, heart medications		
4. Do you feel dizzy when you get up from a bed or chair?		
5. Do you have uncorrected vision problems (glaucoma, cataract, blindness in half of your visual field)?		
6. Are you over 65 years of age?		

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

Patient Signature: _____

Therapist Signature: _____

For Office Use Only:

REFERRALS MADE TO THE FOLLOWING:

Service _____ Date: _____ By: _____

Service _____ Date: _____ By: _____

Physician Contacted _____ Date: _____ By: _____