FALLS SCREENING QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Please answer the following questions:

1. Have you fallen in the past year? _____Yes _____No

   If YES:

   a. How many times have you fallen? _____

   b. Were you injured? _____Yes _____No

2. Do you feel unsteady while standing or walking? _____Yes _____No

FOR OFFICE USE ONLY:

If patient answers YES to either Falls question above, perform TUG test.

Results of TUG test (in seconds): _____

Did patient use assitive device? _____Yes _____No

If yes, what did they use? _____

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply:

Slow tentative pace Loss of balance Short strides

Little or no arm swing Steadying self on nearby objects Shuffling

Notes: