

# Fall Risk Checklist

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
<b>Falls History</b>		
Any falls in past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Worries about falling or feels unsteady when standing or walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medical Conditions</b>		
Problems with heart rate and/or rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cognitive impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foot problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other medical conditions (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medications</b>		
Any psychoactive medications, medications with anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, Tylenol PM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Gait, Strength &amp; Balance</b>		
Timed Up and Go (TUG) Test ≥12 seconds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30-Second Chair Stand Test Below average score (See table on back)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4-Stage Balance Test Full tandem stance <10 seconds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Vision</b>		
Acuity <20/40 OR no eye exam in >1 year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Postural Hypotension</b>		
A decrease in systolic BP ≥20 mm Hg or a diastolic bp of ≥10 mm Hg or lightheadedness or dizziness from lying to standing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other Risk Factors (Specify)</b>		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

