CEP | Patients

Check Your Falls Risk

This checklist will help your healthcare team gather information to see if you are at a higher risk for falls and if so, what steps you can take to reduce your risk. You can have a friend or family member help you complete it.

Patient name: **Date:**

Name of person filling out form (if different)**:**

Please check all the apply and fill out the answers to the best of your knowledge.

Fall history:

- ☐ I have fallen _____ times in the past year
- ☐ I have had one or more close calls, but have not fallen
- ☐ I feel unsteady when walking or standing
- ☐ I am worried I might fall

Note: a fall includes any unplanned change in position to a lower level, including sliding slowly or slipping and having someone catch you.

If you fell in the past year, tell us more about your most recent fall:

When was the fall?

What were you doing at the time of the fall?

What do you think might have caused the fall?

How long did you spend on the ground?

Were you able to get up by yourself?

What symptoms **do you remember having** before the fall?
☐ light-headedness ☐ dizziness ☐ nausea ☐ chest pain ☐ thumping heartbeat ☐ other

What injuries did you have after the fall?

Did you need to change your daily activities?

Did you seek medical attention because of the fall?

What did your healthcare provider recommend to prevent future falls?

Physical activity:

I get about _____ ☐ minutes / ☐ hours (check one) of physical activity each week
(e.g., walking, gardening, housekeeping, fitness classes)

- ☐ I do strength training at least twice a week (e.g., weights, exercise bands, push-ups)
- ☐ I do activities to help with balance (such as yoga or Tai Chi) on most days of the week

Home safety

- ☐ I have had a home safety evaluation (e.g., by CCAC/Home and Community Care or a falls prevention program)
- ☐ I have completed the "CDC Home safety checklist" (provided by my clinic)
- ☐ I have a fall alert device ☐ I wear my fall alert device at all times when home

Nutrition and hydration:

- ☐ I eat regular meals including a variety of healthy foods
- ☐ I have lost weight in the last 6 months (without trying to)
- ☐ I drink at least 2 L (8 cups) per day (not including caffeine or alcohol)
- ☐ My doctor told me to limit my fluid intake
- ☐ I often drink more than 1 alcoholic drink per day (for women) or 1-2 drinks per day (for men)
- ☐ I eat at least 3 servings of calcium-rich foods per day
  (e.g., dairy products, calcium fortified foods or drinks, almonds, tofu)
- ☐ I take calcium supplements. How much do you take per day?
  What type? (e.g., calcium carbonate, calcium citrate)
- ☐ I take vitamin D supplements. How much do you take per day?

Social support

- ☐ I live alone
- ☐ I have someone who can check in on me (e.g., friend, family, neighbour)
- ☐ I have someone who helps me around the home (e.g., hired caregiver, friend, family)
- ☐ I am a caregiver
- ☐ Sometimes I have difficulty making ends meet
- ☐ I don't always feel safe at home

Pain and mobility

When inside my home, I use to help me get around (check all that apply)

☐ a cane ☐ a walker ☐ a wheelchair ☐ a scooter ☐ furniture

When outside of my home, I use to help me get around (check all that apply)

☐ a cane ☐ a walker ☐ a wheelchair ☐ a scooter

- ☐ Pain limits my ability to get around or do things I used to do

Vision

- ☐ I have had an eye exam in the past year
- ☐ My vision is blurry and/or has gotten worse over time
- ☐ I wear multifocal lenses (e.g., bifocals, trifocals, progressives)

Feet and footwear

I wear well-fitting, supportive shoes (check all that apply): ☐ inside my home ☐ when I am outside

- ☐ I have lost some feeling in my feet
- ☐ I have sores on my feet

Other

- ☐ Sometimes I feel dizzy when standing up
- ☐ Sometimes I rush to the bathroom
- ☐ Sometimes I take medication to help me sleep. What type?