Fall Risk Questionnaire

Patient's Name: _____ **Phone #:** _____

Doctor's Name: _____ **Date:** _____

Please complete this assessment to help your doctor determine if you qualify for home health.

1.	Has it been longer than six months since you or a loved one has exercised regularly?	☐ yes	☐ no
2.	Have you or a loved one had a fall or a near fall in the past year?	☐ yes	☐ no
3.	Do you or a loved one have a fear of falling that somewhat limits your activity?	☐ yes	☐ no
4.	Do you or a loved one take four or more medications?	☐ yes	☐ no
5.	Do you or a loved one take medication to treat sleep, nerves, depression, anxiety or pain?	☐ yes	☐ no
6.	Do you or a loved one wear bifocal or trifocal glasses? Is your vision much better in one eye than the other?	☐ yes	☐ no
7.	Are you or a loved one interested in improving mobility or balance?	☐ yes	☐ no
8.	Do you or your loved one's feet or toes often feel hot, cold, numb or tingly?	☐ yes	☐ no
9.	Do you or your loved one feel that no one understands how balance problems and dizziness often affect your quality of life?	☐ yes	☐ no
10.	Do you or a loved one feel unsteady or troubled when walking down a supermarket aisle?	☐ yes	☐ no
11.	Do you or a loved one feel like you are pulled to the side while trying to walk a straight line?	☐ yes	☐ no
12.	Do you or a loved one feel as though your feet won't go where you wish them to go?	☐ yes	☐ no
13.	Do you or a loved one experience a sensation of spinning or dizziness when you tilt your head back, lie down or roll over in bed?	☐ yes	☐ no
14.	Do you or a loved one experience a fainting feeling, loss of balance or light headedness when you stand up?	☐ yes	☐ no
15.	Do you or a loved one have difficulty when walking on gravel, a sloped sidewalk or other uneven surfaces or when walking in the dark?	☐ yes	☐ no

If you answer yes to any ONE of these questions, you might benefit from home health.
Call **866.CARE.KAH** and we will be happy to speak with you about help at home.

Kindred at Home
Our Care Matters