Fall - Risk Screening: Multi-Factorial Questionnaire

Name: ___________________________ Date: ________________
Phone Number: ___________________ Date of Birth: ____________
Family Physician: ________________ PHN: ________________

□ Check mark in box indicates “yes”

Factor 1 History of falls:

□ A fall is defined as **unintentionally** coming to rest on the ground, floor or other lower level with or without injury. Have you fallen and if so, how many times in the past year? ____
□ A near fall is a slip or trip but you were able to catch yourself. Have you experienced a near fall? If so, how many times in the past year? ____
□ Have you visited an emergency department, your family doctor or another health professional as a result of a fall in the past year? If yes, which service?
□ If you fell, would you need help to get up from off the ground?

Factor 2 Medications

□ Do you take more than 3 prescription medications each day?
□ Do you take medications?
□ To help you sleep?
□ To help control mood (e.g. anxiety, depression)?
□ To prevent seizures or control heart rhythm?
□ To control pain?
□ Have there been any recent changes to your medications?
□ Have you felt different, dizzy or unsteady since you had a change in your medication?
□ Do you have more than one drink of alcohol a day?

Factor 3 Gait, Balance, Mobility:

□ Do you feel unsteady when you walk, or notice any balance difficulties during day to day tasks like walking, moving from sit to stand, or changing direction?
□ Do you use a walking aid or has anyone advised you that you should use one?
□ Do you require assistance for day to day tasks such as bathing, showering, preparing meals or other personal care.
**Factor 4 Visual Acuity:**

- Do you have vision problems? Such as blurriness, difficulty seeing to the side, different depths, distances or that you are sensitive to changing light?
- Was your last visit to the optometrist/ophthalmologist over a year or two ago?

**Factor 5 Other neurological and/or cognitive impairments**

- Do you have any neurological conditions such as multiple sclerosis, Parkinson’s disease, or history of stroke?
- Do you notice that you have problems with your memory? (more than normal, more than other people your age do)
- Do family or friends say that you have problems with your memory?
- Do you have trouble completing familiar tasks? (e.g., writing a check, finding your way in a familiar mall/store.)
- Do you have problems with bowel and/or bladder control?

**Factor 6 Muscle Strength**

- Do you have any conditions that have caused muscle weakness in your legs? i.e., arthritis, recent joint surgery, or any other health conditions that have altered your ability to do day to day activities?
- Has your leg or legs ever “given out” on you when climbing stairs, walking, or unexpectedly?
- Do you feel you have leg or ankle weakness or that you tire easily when you walk?

**Factor 7 Heart Rate and rhythm/cardiac impairments**

- Do you have any cardiac conditions such as hypertension, arrhythmia, or a recent heart attack?
- Have you been told that your heart rate is too high or too low?
- Have you noticed any difficulty with getting short of breath easily with day to day activities or you have to stop and rest frequently during the day?

**Factor 8 Postural Hypotension**

- Have you ever fallen because of sudden, unexpected fainting or blackouts?
- Have you been told that you have low blood pressure?
- Do you ever get dizzy when getting out of bed, or standing up from a chair?
- If a blood pressure reading taken, please record value here: _________

**Factor 9 Feet and Footwear**

- Do you have any numbness or loss of sensation in your feet?
- Do you have difficulty wearing shoes due to arthritis or any other conditions?
- Do you commonly wear slippers without backs when in the house?
Factor 10 Environmental hazards

☐ If you have fallen where did it occur?
   ☐ Inside your home
   ☐ Outside your home or yard
   ☐ In the community

☐ Have you fallen repeatedly in one place? If yes, where? ______________________

☐ Were there any hazards in the environment where you fell, that you think contributed to your fall? If yes, what? ______________________

☐ Do you think that a safety check of your home, yard and/or neighbourhood would assist you in avoiding falls?

Other fracture and fall risks

☐ Do you spend most of your day in your home?
☐ Are you fearful of falling, such that it limits your willingness to do activities that you enjoy?
☐ Have you ever broken a bone or been diagnosed with osteoporosis?
☐ If so, are you not currently taking calcium, vitamin D supplements and/or medications to stimulate bone growth?