

Fall Risk Checklist

Patient: _____ Date: _____ Time: _____ AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
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	
Medical Conditions		
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	
Medications		
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	
Gait, Strength & Balance		
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	
Vision		
Acuity <20/40 OR no eye exam in >1 year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Postural Hypotension		
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	
Other Risk Factors (Specify)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Chair Stand—Below Average Scores

Age	Men	Women
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4