

# Are you at risk of falling?



## Checklist

Determine your risk of falling by completing this checklist.

Have you fallen, or nearly fallen, in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take medication for nerves, blood pressure, sleeping problems, depression?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take more than three medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get dizzy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a condition that affects your walking, balance or memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often have to rush to the toilet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you unsteady on your feet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty turning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty with steps/stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use a walking frame or stick?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you hold on to furniture to keep your balance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you exercise less than three times each week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty getting up from a chair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has it been more than 12 months since your last eye check?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you sometimes have difficulty seeing when you are walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a foot condition that affects walking and balance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often miss meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there anything in your garden or home than could make you slip or trip?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty walking outdoors or in public places?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered **YES** to some of the questions above, you may be at risk of falling.

Contact an Occupational Therapist to discuss 9430 9100 (Eltham) or 8820 2220 (Box Hill).