Barrington Rehabilitation
Fall Risk Assessment

Patient Name: ____ Date: _____________________

1. Have you fallen in the last year? ____ Yes ____ No *(If No, STOP)*

2 . If yes, did you sustain an injury from the fall? ____ Yes ____ No

3. Have you had two or more falls in the past year? ____ Yes ____ No *(If No, STOP)*

4. If yes, do you have any of the following in your home? Please select all that apply:
   - ____ Clutter where you walk
   - ____ Exposed electrical cords
   - ____ Furniture or other sharp edged items in the normal pathways through your house
   - ____ Poor lighting
   - ____ Raised doorway thresholds
   - ____ Slippery floors
   - ____ Steps and stairways
   - ____ Throw rugs

5. How many medications do you currently take?
   - ____ None
   - ____ 1
   - ____ 2
   - ____ 3 or 4
   - ____ 5 or more

6. Were you taking any of the following medications at the time of your fall(s)? Please select all that apply.
   - ____ Any central nervous system / psychotropic medications
   - ____ Sedative / hypnotics (sleeping medications)
   - ____ Antidepressants (especially tricyclics)
   - ____ Antipsychotics / neuroleptics
   - ____ Benzodiazapines (“nerve pills”)
   - ____ Cardiovascular drugs
   - ____ Diuretics
   - ____ Antiarythmics
   - ____ Cardiac glycosides
   - ____ Diabetes medication

7. If you were taking any of the above at the time of your fall(s), are you still taking the medications?
   - ____ Yes
   - ____ No