



## Falls Risk Screening

Site Name:

Date:

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Name:

Age:

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ID#

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Have you fallen in the last 12 months?  Yes  No

Are you afraid that you will fall?  Yes  No

Do you use a cane, walker, or other device to help you walk?  Yes  No

If you answered “yes” to any of the questions, you might benefit from a balance assessment by your primary care physician.