Personal Risk Factors for Falling
Self-Assessment

☐ Yes ☐ No	1. Have you fallen before?
☐ Yes ☐ No	2. Have you been injured because of a fall?
☐ Yes ☐ No	3. Have you stopped doing any daily activities or avoided exercise because you're afraid of falling?
☐ Yes ☐ No	4. Do you feel weaker now than in the past or have less strength in your legs?
☐ Yes ☐ No	5. Has your hand strength decreased?
☐ Yes ☐ No	6. Do you feel dizzy when you stand up?
☐ Yes ☐ No	7. Has your eyesight diminished, or do you have difficulty seeing depth or seeing at night?
☐ Yes ☐ No	8. Have you experienced hearing loss?
☐ Yes ☐ No	9. Are you taking one of more of these medications: opioid painkillers, anti-blood clotting drugs, sedatives, antidepressants, calcium, or ulcer/GERD drugs?
☐ Yes ☐ No	10. Do you have foot ulcers, bunions, arthritis, or other conditions that make walking painful?
☐ Yes ☐ No	11. Do you feel unsteady on your feet or shuffle when you walk?
☐ Yes ☐ No	12. Are you unable to make sharp turns or change directions easily while walking?
☐ Yes ☐ No	13. Do you have difficulty navigating stairs, slopes, or curbs?

SPORTS CONDITIONING AND REHABILITATION
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Adapted from the Hamilton County Fall Prevention Task Force