Elderly Fall Risk Assessment Form

Patient Name

Date of Birth

Assessment Date

Assessor Name

History

Has the patient had any falls in the past year?

Yes No

If yes, how many falls?

Mobility & Gait

Does the patient use any mobility aid?

Gait Assessment

Medical & Drug Factors

Does the patient have any of the following conditions?

Osteoporosis Parkinson's Disease Stroke Visual Impairment

Hearing Impairment Other

Does the patient take any medications that may increase fall risk?

Sedatives Antihypertensive Hypoglycemic Agents Other

Environment

Are there environmental hazards at home?

☐ Poor Lighting ☐ Loose Rugs ☐ Lack of Grab Bars ☐ Clutter ☐ Other

Assessment Summary

Summary / Recommendations