Home Health Care Fall Risk Assessment Form

Patient Information

Patient Name

Date of Birth

Medical Record Number

Assessment Date

Fall Risk Factors

History of falls (past 3 months)

Yes No

Mobility Issues (requires assistance, unsteady gait, assistive devices, etc.)

Yes No

Dizziness or Balance Issues

Yes No

Vision Impairment

Yes No

Medications That Increase Fall Risk (e.g., sedatives, antihypertensives)

Yes No

Cognitive Impairment

Yes No

Continence Issues (incontinence, urgency)

Yes No

Environmental Assessment

Potential hazards in the home (loose rugs, clutter, poor lighting, etc.):

Additional Notes / Recommendations

Assessor Name

Signature

Date