Fall Risk Checklist

Patient: Date: Time: ☐☐ AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
Any falls in past year?	☐ Yes ☐ No	
Worries about falling or feels unsteady when standing or walking?	☐ Yes ☐ No	
Medical Conditions		
Problems with heart rate and/or rhythm	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Incontinence	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Foot problems	☐ Yes ☐ No	
Other medical conditions (Specify)	☐ Yes ☐ No	
Medications		
Any psychoactive medications, medications with anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, Tylenol PM)	☐ Yes ☐ No	
Gait, Strength & Balance		
Timed Up and Go (TUG) Test ≥12 seconds	☐ Yes ☐ No	
30-Second Chair Stand Test Below average score (See table on back)	☐ Yes ☐ No	
4-Stage Balance Test Full tandem stance <10 seconds	☐ Yes ☐ No	
Vision		
Acuity <20/40 OR no eye exam in >1 year	☐ Yes ☐ No	
Postural Hypotension		
A decrease in systolic BP ≥20 mm Hg or a diastolic bp of ≥10 mm Hg or lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	
Other Risk Factors (Specify)		
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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