----------fold----------

Please answer these questions to help us understand how you feel about falls prevention:

Are you concerned about losing your balance or falling?

□ Yes □ No

Have you fallen or do you lose your balance?

□ Yes □ No

If YES to ONE or BOTH - Then CONTINUE INSIDE

If you answered NO to BOTH questions- No Need to Continue

[FOR OUR RECORDS ONLY PLEASE TELL US:]

Date: __/__/___ Age: _____ □ Male □ Female

[If your answer was Yes to either question, please continue inside]

How concerned are you about falling or losing your balance?

□ Not Concerned □ Somewhat Concerned □ Very Concerned

How many times did you fall in the LAST 12 months (1 year) ?

□ None □ One □ Two □ Three or more □ Don't Know

Did any fall cause an injury? □ Yes □ No

How many times did you fall between 12 - 24 months ago ?

□ None □ One □ Two □ Three or more □ Don't Know

Did any fall cause an injury? □ Yes □ No

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How many times did you fall in the LAST 3 months ?

□ None □ One □ Two □ Three or more □ Don't Know

Did any fall cause an injury? □ Yes □ No

How OFTEN do you lose your balance or almost fall WITHOUT actually falling?

□ Never □ Occasionally □ 2+x/month □ 1-2x/week □ Daily

WHAT HAPPENS NEXT?

With your permission, someone will contact you to answer any questions you have about falls prevention.

I would like someone to contact me: □ Yes □ No

At this tel. #: _____

My Name is: _____