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

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: ________________________________

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