SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES
SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES
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Name:___________________________ DOB: __________ Date: _______________

FALL RISK ASSESSMENT

Please mark most appropriate answer for each item below:

History of falling within the past three months?
1. Yes 2. No

Do you have a medical condition that would cause you to fall:
1. Yes 2. No

Use of any ambulatory aids:
1. Crutches/cane/walker 2. Furniture 3. Bedridden

Do you have an IV currently in place for ongoing intermittent intravenous therapy?
1. Yes 2. No

Gait/ambulation/ability to walk:
1. Somewhat weak 2. Very impaired 3. Normal 4. Bedridden

Mental Status:
1. Oriented to own ability 2. Forgets limitations

VACCINATION STATUS

Please mark appropriate answer; add last date received if "Yes".

Pneumovax/pneumococcal/pneumonia vaccine: Yes Date: _______ No

Influenza: Yes Date: __________ No

Zoster (Shingles): Yes Date: __________ No