North Louisiana
Orthopaedic & Sports Medicine Clinic
Experience You Can Trust Since 1951

FALL RISK SCREENING

Date ____________________

Patient's Name ____

Patient's Date of Birth ____________________

Please answer the below questions by checking the appropriate box.

1. Have you had one or more falls within the past 12 months? ☐ YES ☐ NO

   1a. Number of falls in the past 12 months _______

2. Have you had a fall with an injury? ☐ YES ☐ NO

3. Do you have any problems with gait or balance? ☐ YES ☐ NO