FALLS RISK ASSESSMENT

_____Have you ever experienced dizziness, unsteadiness, imbalance

or vertigo? Circle: YES NO

- If yes, is your Primary care Physician aware of this? Circle: YES NO
- If yes, what kind of treatment did or are you receiving?

  _____
- If yes, are you feeling dizzy today? Circle: YES NO
- If yes, please describe:

  _____

  _____
- If yes, Frequency of occurrence: _____
- If yes, is it accompanied by (Circle all that apply)
  Nausea ringing or noises in the ear hearing loss
  Visual disturbances other

_____Have you fallen within the past 12 months? Circle: YES NO

- If yes, how many falls have you experienced in the last 12 months? _____
- If you have fallen, have you been injured? Circle : YES NO
- Please describe your injury: _____

Do you experience visual disturbances? Circle: YES NO

- If yes, please describe: _____
- Do you currently take a Vitamin D supplement? Circle: YES NO

For office use only:

Plan of care:

_____ Referred to their physician for Vitamin D Supplement

_____ Referral for an exercise program/physical therapy that must include balance, strength and gait training (vestibular rehabilitation).