

*You may print out this form after you've entered your responses, or print the form first and mark your answers with a pen. We encourage you to share the results on this test with your doctor.*

## **Desmond Fall Risk Questionnaire**

Name \_\_\_\_\_ Date \_\_\_\_\_

YES NO

1.   Have you had a fall or near fall in the past year?
2.   Do you have a fear of falling that restricts your activity?
3.   Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
4.   Do you feel uneasy or unsteady when walking down the aisle of a supermarket, or in an area congested with other people?
5.   Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a sloped sidewalk?
6.   Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
7.   Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
8.   Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
9.   Do you take medication for depression, anxiety, nerves, sleep or pain?
10.   Do you take four or more prescription medications daily?
11.   Do you feel like your feet just won't go where you want them to go?
12.   Do you feel like you can't walk a straight line, or are pulled to the side while walking?
13.   Has it been longer than six months since you participated in a regular exercise program?
14.   Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15.   Are you interested in improving your balance and mobility?

**If you answered yes to one or more of these questions, you should contact your physicians office and share this information or contact the KSB Balance Center at 815-285-5918.**

**Take steps to prevent a fall.**