Name: ______________________ Email: ______________________ Phone: ________________

# Every 14 Seconds, an Older Adult Is Treated in an Emergency Room for a Fall-Related Injury

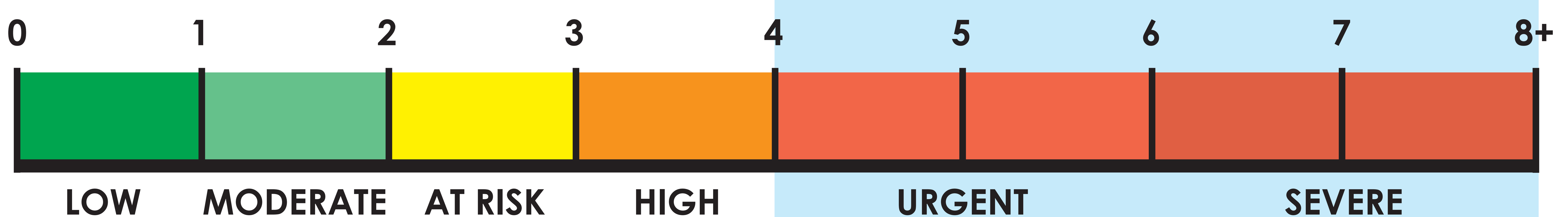
## Take This **Fall Risk** Self Assessment Quiz

### Score Only Your "Yes" Answers

| | | |
|---|---|---|
| Yes (2) | No | I have fallen in the past year. |
| Yes (2) | No | I use or have been advised to use a cane or walker. |
| Yes (1) | No | I sometimes lose my balance when walking. |
| Yes (1) | No | I worry about falling. |
| Yes (1) | No | I use my arms to push myself up from a chair. |
| Yes (1) | No | I sometimes have trouble stepping up onto a curb. |
| Yes (1) | No | My body sways when standing stationary. |
| Yes (1) | No | I take short narrow steps. |
| Yes (1) | No | I stumble often or look at the ground when I walk. |
| Yes (1) | No | I frequently have to rush to the toilet. |
| Yes (1) | No | I have lost some feeling in one or both of my feet. |
| Yes (1) | No | My medication makes me feel light-headed or sleepy. |

**YOUR FALL RISK**

If you scored 4 points or more, schedule your FREE Fall Risk Evaluation Today!

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