Name: Date:

Atlantic Accountable Care Organization

FALL PREVENTION SCREENING

Please answer the following questions by circling either "yes" or "no"

Do you have or have you had any of the following:	YES	NO
A sensation of movement of yourself or the room: spinning or tilting	○	○
Lightheadedness or feeling that you are going to faint	○	○
Loss of balance	○	○
Disassociation or disorientation with the world	○	○
Dizziness or lightheaded when standing up or getting out of bed	○	○
Blacking out or loss of consciousness	○	○
Tendency to fall	○	○
Difficulty hearing	○	○
Fall within the prior year	○	○
Fall related injury within the past year	○	○