NORTH FULTON HOSPITAL

Pain & Spine Center

FALL RISK ASSESSMENT

1. Do you need help getting dressed? Yes [ ] No [ ]
2. Do you have trouble standing? Yes [ ] No [ ]
3. Do you need help with walking? Yes [ ] No [ ]
    a. If yes, what do you use?

        Cane [ ] Walker [ ] Wheel chair [ ] Brace [ ]
4. Have you fallen in the past 60 days? Yes [ ] No [ ]
    a. If yes, have you experienced any injury from your fall?

        Yes [ ] Describe: _____ No [ ]

If you have answered **"YES"** to any question or need assistance at any time, please notify any staff member so we can assist you.

Patient Signature: _____

Employee Signature: _____ Date: _____

Patient Label Here