

Please answer all questions

Name: _____ Date: _____

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