<table>
<thead>
<tr>
<th>Falls Risk Questionnaire</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you tripped or fallen during the last year?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>2. Do you have trouble keeping your balance?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Self-assessment of Health Status, Frailty, and Physical Functioning (ADLs &amp; IADLs)</td>
<td></td>
</tr>
<tr>
<td>3. How does your health compare to most people your age?</td>
<td>Great ☐ Good ☐ Fair ☐ Poor ☐</td>
</tr>
<tr>
<td>4. Do you need help with dressing, bathing, eating, using the toilet, or grooming?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>5a. In the past year, has lack of transportation kept you from medical appointments or from getting medications?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>5b. In the past year, has lack of transportation kept you from meetings, work, or getting things needed for daily living?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>6. Do you need help making food or doing housework?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>7. Do you have trouble managing your money or your medications?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>8a. Do you leak urine?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>8b. Do you leak stool or lose control of your bowels?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>9. Do you have serious difficulty walking or climbing stairs?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>10. Are you deaf or do you have serious trouble hearing?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>11. Are you legally blind or do you have serious trouble seeing, even if you wear glasses?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>12a. On average, how many days per week do you engage in moderate to strenuous exerc (like a brisk walk?)</td>
<td>0 1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td></td>
</tr>
<tr>
<td>13. Do you have new memory problems in the past year?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>14. Do you have trouble thinking clearly or making decisions?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Providers &amp; Advance Directive</td>
<td></td>
</tr>
<tr>
<td>15. Have you seen other providers in the past year?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>16. Do you have a medical power of attorney/advance directive?</td>
<td>Yes ☐ Don't Know ☐ No ☐</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td></td>
</tr>
<tr>
<td>17. Which of these medical supplies do you use?</td>
<td>None ☐ Oxygen ☐ CPAP supplies ☐ Cane, walker or wheelchair ☐ Ostomy supplies ☐ Other ☐</td>
</tr>
<tr>
<td>Additional Systems</td>
<td></td>
</tr>
<tr>
<td>18. Have you unintentionally lost weight in the past year?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>19. In the past 2 weeks, have you had more pain than usual?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>20. In the past 2 weeks, have you had more fatigue than usual?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>21. In the past 2 weeks, have you had more trouble breathing than usual?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>22. In the past 2 weeks, has your appetite or bowel function changed?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>23. In the past 2 weeks have you experienced unexplained lightheadedness or dizziness?</td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

**Please continue to questions 24-36 on page 2**
**Psychosocial & Safety Risks**

**PHQ-2: Over the last 2 weeks, how often have you been bothered by any of the following**

24. Little interest or pleasure in doing things?  
   - Not at All  
   - Several days  
   - More than half the days  
   - Nearly every day

25. Feeling down, depressed, or hopeless?  
   - Not at All  
   - Several days  
   - More than half the days  
   - Nearly every day

26a. Within the last year, have you been afraid of your partner or ex-partner?  
   - Yes  
   - No

26b. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?  
   - Yes  
   - No

26c. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?  
   - Yes  
   - No

27. Do you feel safe at home?  
   - Yes  
   - No

28. Are you a caregiver for another person?  
   - Yes  
   - No

29. In a typical week, how many times do you talk on the phone with family, friends, or neighbors?  
   - Never  
   - Once  
   - Twice  
   - Three  
   - More than three

30. Whom do you live with?  
   - Spouse/Partner  
   - Assisted/Group Living  
   - Friend/Family  
   - Alone

**Behavioral Risks (Social, Nutrition, & Safety)**

31a. How often do you have a drink containing alcohol?  
   - Never  
   - One per month  
   - 2 to 4 monthly  
   - 2 to 3 weekly  
   - 4 or more weekly

31b. How many drinks containing alcohol do you have on a typical day when you are drinking?  
   - 1 to 2  
   - 3 to 4  
   - 5 to 6  
   - 7 to 9  
   - 10 or more

31c. Do you use recreational drugs or prescription medications for non-medical reasons?  
   - Never  
   - Not in past year  
   - Yes

31d. Tobacco Use  
   - Never  
   - Former use  
   - Yes

32a. How many sexual partners have you had in the last year?  
   - Zero  
   - One  
   - Two or more

32b. With whom have you had sex?  
   - Men  
   - Women  
   - Both  
   - Other

33. Do you think your diet is unhealthy?  
   - No  
   - Yes

34. Do you take herbal or vitamin supplements that are not on your medication list?  
   - No  
   - Yes

35. Have you been to a dentist during the last year?  
   - Yes  
   - No

36. Do you use a seat belt when riding in a vehicle?  
   - Yes  
   - No

**Patient's Signature:**

**Date:**

**Medical Staff Initials (Clinical Support or Provider):**

**Date:** (rev 2022.1.13)