

# SOUTHPORT PHYSIOTHERAPY CENTRE

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## A Quick Check List for Knowing Your Risk of Falling



Take a couple of minutes to complete this checklist.

- |   |                |
|---|----------------|
| • I have had at least 1 fall in the last 6 months   | Yes /No/unsure |
| • I take sleeping tablets or tranquilisers or antidepressants   | Yes/No/unsure  |
| • I do less than 30 minutes of physical activity a day (eg brisk walk, swim, cycle or group exercise)   | Yes/No/unsure  |
| • I do less than 2 sessions of balance and strength exercise per week (eg Tai Chi or exercise program provided by a health care professional) | Yes/No/unsure  |
| • I have difficulty getting up from a chair   | Yes/No/unsure  |
| • I have poor balance when walking  | Yes/No/unsure  |
| • I have foot pain when walking, swelling or deformity of the feet  | Yes/No/unsure  |
| • I have difficulty with my vision  | Yes/No/unsure  |
| • It has been more than 12 months since my eyes were tested or glasses checked  | Yes/No/unsure  |
| • I have difficulty with my vision even when wearing my Glasses   | Yes/No/unsure  |

### Health Conditions:

- |   |               |
|---|---------------|
| • Heart, blood pressure or circulation issues | Yes/No/unsure |
| • Stroke                                      | Yes/No/unsure |
| • Diabetes                                    | Yes/No/unsure |
| • Parkinson's Disease                         | Yes/No/unsure |
| • Dizziness or funny turns                    | Yes/No/unsure |
| • Incontinence or need to hurry to the toilet | Yes/No/unsure |
| • A recent major change in my health          | Yes/No/unsure |

If you answered **yes** or **unsure** to two or more of these questions you may be at increased risk of fall – This could compromise your independence and mobility.

You may like to consult your GP or physiotherapist for advice regarding ways to address these factors in order to maximise independence, mobility and function and reduce the risk of injury.