Detailed Fall Information

Date of Fall: _____

Please check the boxes as appropriate:

When did this happen?

Morning ☐ Afternoon ☐

Evening ☐ Night ☐

Where did this happen?

Outside ☐ At Home ☐

At a Friend's ☐ Other Indoor Location ☐

Other: _____

Were you using your walker/cane/orthotics/other walking aid when the fall/near miss happened?

Yes ☐ No ☐ I don't have one ☐

What do you think caused you to fall or almost fall?

Alcohol consumption in the last 12 hours: _____

Medications used in the last 12 hours: _____