ORCATECH
SUCCESSFUL AGING WITH TECHNOLOGY

phone: (503) 494-0976
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Subject Fall Report Form

Subject Name: _____ Subject ID: __ __ __ __ __

Date of Fall: __ __/__ __/__ __ Date is: ☐ Exact ☐ Approximate
M D Y

General Description of Fall:

1) Where did the fall occur?

☐ At home
- ☐ Living room
- ☐ Bathroom
- ☐ Kitchen
- ☐ Bedroom
- ☐ Stairs
- ☐ Hallway

☐ Away from home, but indoors
☐ Outdoors
☐ Uncertain
☐ Other: _____

2) What was the cause of the fall? (Check all that apply)

☐ Slip/trip
☐ Lost my balance
☐ Stairs/step
☐ Uneven surface
☐ Light-headed/faint
☐ Vertigo/spinning
☐ Overexertion/exercise
☐ Distracted
☐ Uncertain
☐ Other: _____

3) What was the approximate time of the fall?

_____

4) What was the lighting?

☐ Well-lit
☐ Dark or low light
☐ Uncertain

5) Were there any injuries? (Check all that apply)

☐ No injuries
☐ Stiffness/soreness/back pain
☐ Cut or bruise
☐ Head injury
Describe: _____
☐ Sprain
☐ Fracture
☐ Uncertain
☐ Other: _____

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6) Did you see a healthcare professional because of the fall? (Check all that apply)

- ☐ No
- ☐ Home/facility nurse
- ☐ Paramedic/ambulance
- ☐ Emergency room (ER)
- ☐ Doctor's office
- ☐ Uncertain
- ☐ Other: _____

7) Did you require treatment? (Check all that apply)

- ☐ No
- ☐ Bandage (dressing, etc.)
- ☐ Stitches
- ☐ Cast/boot/splint/ACE wrap
- ☐ Hospitalization
- ☐ Medication (pain medicines, muscle relaxants, etc.)
- ☐ Uncertain
- ☐ Other: _____

8) Did you have any visitors during the first week after the fall?

- ☐ No
- ☐ Yes
  - *Who:* _____ *Related to the fall:* ☐ *Yes* ☐ *No*
  - *Start Date:* __ __/__ __/__ __ (M D Y) *End Date:* __ __/__ __/__ __ (M D Y)
- ☐ Uncertain

9) Are you walking differently after the fall? (Check all that apply)

- ☐ No change
- ☐ Slowly and cautiously
- ☐ Limping
- ☐ Now using a cane or walker
- ☐ Uncertain
- ☐ Other: _____

Any additional comments:

< Start Over Verify >