

Center for Balance, Gait & Fall Prevention

HVCPA Gait Analysis Lab Registration Form

Prevent a Fall

15 Mt Ebo Road South; Brewster, NY

(P) 845/ 878-9078



Please fill in the following form, which helps us check your risk for falling!

Name: _____(Last), _____(First)

Please answer the following 12 questions, by circling YES or NO

YES NO

1	<input type="radio"/>	<input type="radio"/>	I have fallen in the past year
2	<input type="radio"/>	<input type="radio"/>	I use or have been advised to use a cane/walker to get around safely
3	<input type="radio"/>	<input type="radio"/>	Sometimes I feel unsteady when I am walking
4	<input type="radio"/>	<input type="radio"/>	I steady myself by holding on to furniture when walking at home
5	<input type="radio"/>	<input type="radio"/>	I am worried about falling
6	<input type="radio"/>	<input type="radio"/>	I need to push with my hands to stand up from a chair
7	<input type="radio"/>	<input type="radio"/>	I have some trouble stepping up onto a curb
8	<input type="radio"/>	<input type="radio"/>	I often have to rush to the toilet
9	<input type="radio"/>	<input type="radio"/>	I have lost some feelings in my feet
10	<input type="radio"/>	<input type="radio"/>	I take medicine that sometimes makes me feel light-headed or more tired than usual
11	<input type="radio"/>	<input type="radio"/>	I take medicine to help me sleep or improve my mood
12	<input type="radio"/>	<input type="radio"/>	I often feel sad or depressed

Total _____	Add up the number of points for each "YES" answer. If you scored 4 points or more, you may be at risk for falling. Use of the OptoGait system can help clarify this risk. Discuss these outcomes with your doctor
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