WHFM2

Western Health

Patient Bradma

NAME:.....

UR:.....

ADDRESS:.....

DATE OF BIRTH: .....

FALLS DIARY

Please complete the following table as accurately as you can about your most recent falls. If you have difficulty in completing this form, the clinic staff will happily assist you at your first visit.

HAVE YOU FALLEN IN THE LAST 12 MONTHS? (please circle one)

☐ NO ☐ YES – number of times _____

	Fall 1	**Fall 2**	**Fall 3**	**Fall 4**
Date of fall?				
Where were you when you fell?				
What were you doing just before you fell?				
Were you able to get up by yourself after the fall?				
Did you see a doctor? If yes, what did the doctor do?				
Did you injure yourself?				
Did you have any warning signs? If yes, describe…				
Did you black out?				
Did you trip or slip on something? If yes, describe….				
Have you changed your level of activity since the fall? If yes, describe….				

Any further information you think is important.