Patient Name:_____ **Date:**_____

DESMOND FALL RIS-K QUESTIONNAIRE – Please circle your answer for each question.

1. Have you had a fall or near fall in the past year? **YES / NO**
2. Do you have a fear of falling that restricts your activity? **YES / NO**
3. Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back or roll over in bed? **YES / NO**
4. Do you feel uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people? **YES / NO**
5. Do your feet or toes frequently feel unusually hot, cold, numb or tingly? **YES / NO**
6. Do you wear bifocal or trifocal glasses, or is your vision noticeably better in one eye? **YES / NO**
7. Do you experience loss of balance or a lightheaded/faint feeling when you stand up? **YES / NO**
8. Do you take medication for depression, anxiety, nerves, sleep or pain? **YES / NO**
9. Do you take four or more prescription medications daily? **YES / NO**
10. Do you feel like your feet just won't go where you want them to go? **YES / NO**
11. Do you feel like you can't walk a straight line, or are pulled to the side when walking? **YES / NO**
12. Has it been longer than 6 months since you participated in regular exercise? **YES / NO**
13. Do you feel that no one really understands how much dizziness and balance problems affect the quality of life? **YES / NO**
14. Are you interested in improving your balance and mobility? **YES / NO**