# PELHAM PHYSICAL MEDICINE DIAGNOSTIC & TREATMENT CENTER

**2118 WILLIAMSBRIDGE ROAD / BRONX, NY 10461 / Tel. 718-823-3900/FAX 718-823-3961**

**Patient Name:_____**
**Attorney:_____**

**Date:_____** **Ins:_____**

## *ARE YOU AT RISK FOR A FALL?*

***(Circle Your Choice to the Following)***

***Do You:***

| | | |
|---|---|---|
| 1. Have frequent slips, trips, near falls or falls? | Yes | No |
| 2. Have difficulty keeping your balance? | Yes | No |
| 3. Feel dizzy: | | |
| When standing and walking? | Yes | No |
| With head movement? | Yes | No |
| 4. Have difficulties walking on uneven surface? | Yes | No |
| 5. Occasionally have “spinning sensation”? | Yes | No |
| 6. Take three or more medications? | Yes | No |
| 7. Drink alcohol frequently? | Yes | No |
| 8. Do you experience noise & ringing in your ears? | Yes | No |
| 9. Do you have hearing problems? | Yes | No |