STEADI Fall Risk

1. Have you fallen in the past year?	○ **Yes**	○ **No**
2. Do you use or have you been advised to use a cane or walker to get around safely?	○ **Yes**	○ **No**
3. Do you sometimes feel unsteady while walking?	○ **Yes**	○ **No**
4. Do you steady yourself by holding onto furniture when walking at home?	○ **Yes**	○ **No**
5. Do you worry about falling?	○ **Yes**	○ **No**
6. Do you need to push with your hands to stand up from a chair?	○ **Yes**	○ **No**
7. Do you have trouble stepping up onto a curb?	○ **Yes**	○ **No**
8. Do you often have to rush to the toilet?	○ **Yes**	○ **No**
9. Have you lost some feeling in your feet?	○ **Yes**	○ **No**
10. Do you take medicine that sometimes makes you light-headed or more tired than usual?	○ **Yes**	○ **No**
11. Do you take medicine to help you sleep or improve your mood?	○ **Yes**	○ **No**
12. Do you often feel sad or depressed?	○ **Yes**	○ **No**