Total Care Family Practice
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Balance Self- Test

1. Have you fallen in the past year? ☐ Yes ☐ No
2. Do you feel dizzy or off balance if you make a sudden change in movement, such as bending down or quickly turning? ☐ Yes ☐ No
3. Do you have any hearing loss? ☐ Yes ☐ No
4. Do you require assistance to walk, such as a Person supporting you, use a walker or a wheelchair? ☐ Yes ☐ No
5. Do you have balance problems when you are walking or climbing stairs? ☐ Yes ☐ No

Signature: ____

Patient Name: ____

Date: ____