Boulder Community Health
Ambulatory Services Department

Clinic Name:____________________ Provider:______________________

Patient Fall Assessment

Name_______________________________________ **Date**_____________________________

DOB____

Please complete for all new patients and patients 65 or older, have recently experienced a fall, or feel you are at risk for a fall.

Fall Assessment

1. Have you fallen more than once in the past year?
   ❒ Yes ❒ No

2. Have you experienced a stroke or other neurological problems that have affected your balance?
   ❒ Yes ❒ No

3. Do you feel unsteady when you are walking or climbing stairs?
   ❒ Yes ❒ No

4. Are you currently taking any medications that may affect your balance?
   ❒ Yes ❒ No

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Nutritional and Learning Needs

Name____ **Date**_________________________________

DOB____

Nutritional Assessment

1. Have you experienced unexplained weight loss?
☐ Yes ☐ No

2. Are you a newly diagnosed diabetic?
☐ Yes ☐ No

3. Are you experiencing nausea, diarrhea or vomiting?
☐Yes ☐No

4. Would you like to speak to someone about a nutritional consult?
☐Yes ☐No

Learning Needs Assessment

Are there any factors or needs that you feel may influence your ability to learn, and may interfere with meeting your treatment or plan of care?

Check all that apply:

☐ Physical Limitations
☐ Language Barrier
☐ Cognitive Limitations
☐ Religious/Cultural Practices
☐ Emotional Barrier
☐ Desire/Motivation
☐ Literacy
☐ Pain/Discomfort
☐ Financial Implications
☐ None
☐ Other: ______________________.

I learn best by: Check all that apply

☐ Visual (Video)
☐ Reading (Written Material)
☐ Doing (Examples)
☐ Listening (Verbal Tapes)
☐ N/A

Primary Language Spoken: ________________

Patient Initials:__________________ Date:____________________