We would like you to keep a diary about any falls that you might have. Please mark the appropriate box (es) every day to indicate when you have not fallen or when you have almost fallen and/or when you have had an actual fall. Please record the number of falls and near falls you experience in the space provided on the daily calendar. If you have a fall that requires medical attention, please remember to tell us about this at your next study visit.

Falls Data Collection Grid

| **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| --- | --- | --- | --- | --- | --- | --- |
| Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls:  | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: |
| Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls:  | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: |
| Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls:  | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: |
| Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls:  | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: |
| Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls:  | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: | Date:[ ]  No Falls[ ]  Near Falls:[ ]  Falls: |

**Enter Details for Each Fall (use additional pages as necessary)**

Date: Time of Day: [ ]  am [ ]  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

[ ]  Only socks

[ ]  Socks and shoes/sneakers

[ ]  Leg braces

[ ]  Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

[ ]  Cane [ ]  Walker [ ]  One crutch [ ]  Two crutches

[ ]  Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

[ ]  I fell while transferring to or from my wheelchair

[ ]  I fell while transferring into the shower/bath

[ ]  I fell while moving my wheelchair

[ ]  When I fell, I was (check all apply):

 [ ]  Being helped by someone else

 [ ]  Using equipment such as a transfer board, hoyer lift, etc.

 [ ]  Using other equipment

Date: Time of Day: [ ]  am [ ]  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

[ ]  Only socks

[ ]  Socks and shoes/sneakers

[ ]  Leg braces

[ ]  Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

[ ]  Cane [ ]  Walker [ ]  One crutch [ ]  Two crutches

[ ]  Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

[ ]  I fell while transferring to or from my wheelchair

[ ]  I fell while transferring into the shower/bath

[ ]  I fell while moving my wheelchair

[ ]  When I fell, I was (check all apply):

 [ ]  Being helped by someone else

 [ ]  Using equipment such as a transfer board, hoyer lift, etc.

 [ ]  Using other equipment

Date: Time of Day: [ ]  am [ ]  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

[ ]  Only socks

[ ]  Socks and shoes/sneakers

[ ]  Leg braces

[ ]  Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

[ ]  Cane [ ]  Walker [ ]  One crutch [ ]  Two crutches

[ ]  Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

[ ]  I fell while transferring to or from my wheelchair

[ ]  I fell while transferring into the shower/bath

[ ]  I fell while moving my wheelchair

[ ]  When I fell, I was (check all apply):

 [ ]  Being helped by someone else

 [ ]  Using equipment such as a transfer board, hoyer lift, etc.

 [ ]  Using other equipment

## Falls Diary CRF Module Instructions

## General Instructions

This form contains data elements to track patient falls and near falls.

## Specific Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*

* Falls Data Collection Grid: – If a near fall or falls is checked, indicate the number.