Fear of Falling Questionnaire

Name:_____ **Phone #:**_____

Please answer the following questions that are related to your balance. For each statement, please check one box to say how the fear of falling has or has not affected you. If you do not currently do the activities in question, try to imagine how your fear of falling would affect your participation in these activities. If you normally use a cane or walker, do these activities or hold on to someone, rate how your fear of falling would affect you as if you were not using these supports.

Due to my fear of falling I avoid…	Completely Disagree	Disagree	Unsure	Agree	Completely Agree
Walking					
Lifting, and carrying objects (i.e. A gallon of milk, dishes)					
Going up and downstairs					
Walking of different surfaces (i.e. grass, uneven ground)					
Walking in crowed places					
Walking in dimly lit, or unfamiliar places					
Leaving Home					
Getting in and out of a chair					
Showering or bathing					
Exercise					
Preparing meal (planning, cooking, serving					
Doing housework (cleaning, vacuuming, washing clothes)					
Work or do volunteer work					
Recreational and leisure activities (i.e. hobbies, socializing, traveling)					