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we're here for you

Falls & Balance Clinic

Self Referral Pre-Registration Questionnaire

Patient Details		Referrer Details	
Name		Name	
D.o.B		Provider Number	
Home Ph		Clinic Name	
Mobile Ph		Address	
Address			
		Phone	
Mailing Address		Fax	
Email			

Health Care or Concession Card? ☐ Yes ☐ No
Aboriginal Descent? ☐ Yes ☐ No
Torres Strait Islander Descent? ☐ Yes ☐ No
Culturally and Linguistically Diverse Background? ☐ Yes ☐ No

Tick the boxes below that apply to you

Are currently using a walking stick or other gait aid?	☐ yes ☐ no
How many falls in **last 3 months?** Including slip/trip, lost balance, room/head spinning, legs unsteady/gave way	☐ 0-2 ☐ 2-4 ☐ +5
How many falls in **last 12 months?** Slip/trip, lost balance, room/head spinning, legs unsteady/gave way	☐ 0-2 ☐ 2-4 ☐ +5
History of collapsing and/or legs giving way?	☐ yes ☐ no
History of feeling dizzy or lightheaded?	☐ yes ☐ no
Fear of falling and/or low confidence?	☐ yes ☐ no
Any visual impairment?	☐ yes ☐ no
Any loss of sensation or feeling in one or both feet?	☐ yes ☐ no
Any history of vertigo or other vestibular issue?	☐ yes ☐ no

Add any extra relevant information in the box to the right	

Signature

Date

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