

Patient name \_\_\_\_\_

Date \_\_\_\_\_

# FALLS AND MOBILITY DISORDERS

## History of Present Illness:

1. If patient fell, date of last fall: \_\_\_\_\_

2. Circumstances of fall: **YES** **NO**

Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Tripped/stumbled over something	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness/palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Unable to get up within 5 minutes	<input type="checkbox"/>	<input type="checkbox"/>
Needed assistance to get up	<input type="checkbox"/>	<input type="checkbox"/>

3. Orthostatics: (Measure after 1-2 min. in specified position)

Lying: BP: \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_

Standing BP: \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_

4. Psychotropic medications (specify): **YES** **NO**

Neuroleptics: _____	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines: _____	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants: _____	<input type="checkbox"/>	<input type="checkbox"/>

5. Uses device for mobility: **YES** **NO**

Cane.....	<input type="checkbox"/>	<input type="checkbox"/>
Walker.....	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair.....	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify.....	<input type="checkbox"/>	<input type="checkbox"/>

6. Vision: **YES** **NO**

Noticed recent vision change.	<input type="checkbox"/>	<input type="checkbox"/>
Eye exam in past year.....	<input type="checkbox"/>	<input type="checkbox"/>

If no eye exam in past year, Visual acuity today:

OS:20/\_\_\_\_\_ OD: 20/\_\_\_\_\_ OU:20/\_\_\_\_\_

7. 2 or more drinks of alcohol each day **YES** **NO**

	<input type="checkbox"/>	<input type="checkbox"/>
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8. Other conditions **YES** **NO**

	<input type="checkbox"/>	<input type="checkbox"/>
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specify: \_\_\_\_\_

(e.g.Parkinson's, CVA, cardiac, neuropathy, severe OA),

## EXAMINATION: (complete as appropriate) **PASS** **FAIL**

1. **Cognition: 3-item recall**.....

**MMSE**.....

**OTHER**.....

2. **Gait**  Normal  Abnormal

Abnormal if:

\*Hesitant start      \*Extended arms

\*Broad-based gait    \*Heels do not clear floor

\*Path deviates        \*Heels do not clear toes of other foot

3. **Balance:** **YES** **NO**

Side-byside, stable 10 sec.....	<input type="checkbox"/>	<input type="checkbox"/>
Semi-tandem, stable 10 sec.....	<input type="checkbox"/>	<input type="checkbox"/>
Full tandem, stable 10 sec.....	<input type="checkbox"/>	<input type="checkbox"/>

If indicated: **YES** **NO**

Can pick up penny off floor.....	<input type="checkbox"/>	<input type="checkbox"/>
Resistance to nudge.....	<input type="checkbox"/>	<input type="checkbox"/>

4. **Neuromuscular:** **YES** **NO**

Quad strength:	<input type="checkbox"/>	<input type="checkbox"/>
Can rise from chair w/o using arms	<input type="checkbox"/>	<input type="checkbox"/>
Rigidity (e.g., cogwheeling).....	<input type="checkbox"/>	<input type="checkbox"/>
Bradykinesia.....	<input type="checkbox"/>	<input type="checkbox"/>
Tremor.....	<input type="checkbox"/>	<input type="checkbox"/>

If indicated, hip ROM and knee exam: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Diagnosis/Treatment Plan:

**Lab/Tests:**  EKG  Holter monitoring

Other: \_\_\_\_\_

**Impression:**  Strength Problem  Balance problem

Parkinsonism  Severe hip/knee OA

Other: \_\_\_\_\_

## Treatment: (the forms below can be printed from the ACOVE video program)

**Patient education handouts:**

- Falls & Mobility Disorders Patient Information Sheet
- Home Safety Checklist
- Strength/balance exercises:
  - Upper body
  - Lower body
- Falls & Mobility Disorders: Community Resources

**Patient counseled:**

- Referral for PT
- Assistive device: \_\_\_\_\_
- Referral for home safety inspection/modifications
- Change in medication(s): \_\_\_\_\_
- Referral for eye exam
- Cardiology consult
- Community exercise program
- Neurology consult
- Other: \_\_\_\_\_