NAME_____ DATE_____

**FALLS EFFICACY SCALE: How confident are you with each task? (circle the number that best applies)**

**Take a bath or shower**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Reach into cabinets or closets**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Walk around the house**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Prepare meals not requiring carrying heavy or hot objects**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Get in and out of bed**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Answer the door or telephone**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Get in and out of a chair**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Getting dressed and undressed**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

**Personal grooming (i.e. washing your face)**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

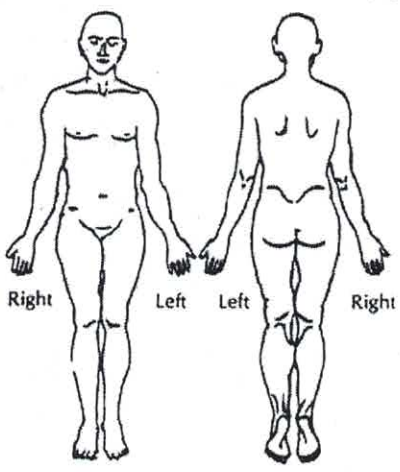
**Getting on and off of the toilet**
1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

***HAVE YOU HAD PHYSICAL THERAPY AT HOME OR AT ANOTHER CLINIC THIS CALENDAR YEAR?**YES ( ) NO ( )

IF "YES", PLEASE LIST NAME OF AGENCY: _____

DATE OF DISCHARGE: _____

**Please Mark the area(s) of pain:




[OFFICE USE]:
BP_____ HR_____ LOCATION_____

WEIGHT_____ HEIGHT_____