

Name:

FALLS DIARY

Date:

Time:

Where did you fall? _____

What happened?

Did you trip? Yes No

Did you have any of the following symptoms before you fell?

Dizziness Palpitations Legs gave way Blacked out

Did you hurt yourself? Yes No

If yes, where did you hurt yourself? _____

Could you get up from the floor? Yes No

If no, how did you get help? _____

Did you see a doctor? Yes GP A&E No