

Form Approved

OMB No: 0920-xxxx

Exp. Date: xx-xx-xxxx

Public Reporting burden of this collection of information is estimated at 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NW, MS D-74, Atlanta, GA 30333; Attn: PRA (0920-xxxx).

Falls Calendar - August 2017

As part of your participation in the Health and Stability Survey, at the beginning of every month you will be asked about your falls during the prior month. For purposes of these monthly surveys, a fall is being defined as an event that resulted in a person unintentionally coming to rest on the ground, floor, or other lower level. This calendar is therefore being provided to help you keep track of any falls so you can accurately complete these monthly surveys. Please check the “Fall” box for any days that you fell.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	01	101 <input type="checkbox"/> Fall	201 <input type="checkbox"/> Fall	3 <input type="checkbox"/> Fall	4 <input type="checkbox"/> Fall	5 <input type="checkbox"/> Fall
6 <input type="checkbox"/> Fall	7 <input type="checkbox"/> Fall	8 <input type="checkbox"/> Fall	9 <input type="checkbox"/> Fall	10 <input type="checkbox"/> Fall	11 <input type="checkbox"/> Fall	12 <input type="checkbox"/> Fall
131 <input type="checkbox"/> Fall	14 <input type="checkbox"/> Fall	15 <input type="checkbox"/> Fall	16 <input type="checkbox"/> Fall	17 <input type="checkbox"/> Fall	18 <input type="checkbox"/> Fall	19 <input type="checkbox"/> Fall
201 <input type="checkbox"/> Fall	21 <input type="checkbox"/> Fall	22 <input type="checkbox"/> Fall	23 <input type="checkbox"/> Fall	24 <input type="checkbox"/> Fall	25 <input type="checkbox"/> Fall	26 <input type="checkbox"/> Fall
27	28	29	30	31		

<input type="checkbox"/> Fall	<input type="checkbox"/> Fall	<input type="checkbox"/> Fall	<input type="checkbox"/> Fall	<input type="checkbox"/> Fall		
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Falls Tracking Log

Please provide the details of any falls you noted on the calendar in this log. Again, completing this information will help you accurately complete the monthly surveys for the Health & Stability Survey.

Date	Time	Location	Cause	Comments	Injuries
MM/DD/YY	<ul style="list-style-type: none"> • Morning • Afternoon • Evening • Overnight 	<ul style="list-style-type: none"> • Inside of home • Outside of home (immediately outside door, in yard, etc.) • In community (away from home) 	<ul style="list-style-type: none"> • Trip • Slip • Loss of balance • Knees gave way • Fainted • Feeling dizzy or giddy • Alcohol or medications • Fell out of bed • Pets • Stairs • Unknown • Other (please specify) 	Please provide any further description of the fall (e.g., what you were doing when it occurred, whether anyone was with you).	Please describe any injuries resulting from the fall and whether they required medical attention. Please indicate any treatment sought for these injuries (e.g., no treatment, doctor's visit, ER, hospital).
1/1/17	AM	Outside home	Loss of balance	While taking walk around the neighborhood with dog.	Scraped hands, sprained knee. Doctor's visit to check knee.

