PATIENT NAME: ____ **DATE:** ______________________

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity**: 0 1 2 3 4 5 6 7 8 9 10**

NEURO – MODIFIED FALLS SCALE – INITIAL AND FOLLOW UP VISIT

	Not Confident At All (0)				*Fairly Confident (5)*			*Completely Confident (10)*			
1. Get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10
2. Prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10
3. Take a bath or shower	0	1	2	3	4	5	6	7	8	9	10
4. Get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10
5. Get in/out of bed	0	1	2	3	4	5	6	7	8	9	10
6. Answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10
7. Walk around the inside of your house	0	1	2	3	4	5	6	7	8	9	10
8. Reach into cabinets or closets	0	1	2	3	4	5	6	7	8	9	10
9. Light housekeeping	0	1	2	3	4	5	6	7	8	9	10
10. Simple shopping	0	1	2	3	4	5	6	7	8	9	10
11. Using public transportation	0	1	2	3	4	5	6	7	8	9	10
12. Crossing roads	0	1	2	3	4	5	6	7	8	9	10
13. Light gardening or hanging out the wash	0	1	2	3	4	5	6	7	8	9	10
14. Using front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10

Office use only: Patient ID#:_____________________________________