Falling in the Netherlands: prevention, care, and follow-up of fall-related injury
Boele van Hensbroek, P.

Citation for published version (APA):
Appendix

The CAREFALL Triage Instrument, version 007, October 2004

Fall-questionnaire
[to be completed by the person who fell, if necessary with a close relative or friend]

| Name: _______________________ | Date: _______________________ |
| Date of birth: ________________ | O male | O female |

Did your General Practitioner refer you to the Emergency Department?  O yes  O no
Do you live alone?       O yes  O no
Before the fall, did you receive help from your partner, neighbor or homecare/district nursing?     O yes  O no
Since the fall, do you receive help from your partner, neighbor or homecare/district nursing?     O yes  O no

How often do you fall?
1. Was this fall your first fall?      O yes  O no
If yes, please proceed to question 4.
2. How often did you fall in the last 12 months? _________
3. On average, how often do you fall?
   O daily
   O at least once per week
   O at least once per month
   O at least once per year

Circumstances of the fall.
4. Do you usually fall.....  O at home  O elsewhere  O both
5. According to you, what was the cause of your (last) fall?
   O accident/trip/slip
   O faint
   O other, namely: ________________
6. Is there anyone who witnessed the fall?  O no  O yes, namely: _______________

The following questions concern all falls that you have sustained, even if this was your first fall.
7. Do you remember how you fall?   O yes  O no  O I do not know
8. When you fall, or when you have the feeling that you almost fall, does this happen?: (multiple answers possible)
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. while getting up (from a bed or a chair)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. when turning your head or shaving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. at night while getting out of bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. within 2 hours after a meal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. while coughing of laughing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. on the toilet while urinating or defecating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. in warm weather or a warm environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. after prolonged standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. with emotional stress or pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. caused by an accident (e.g. slip or trip)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. while exercising</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you feel the fall coming up?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what are your complaints before you fall? (multiple answers possible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. dizziness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. black before eyes or light feeling in head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. heart palpitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. chest pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. tingling in the hands or around the mouth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. warm sensation in the belly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. blurred vision / double-sight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. headache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. transpire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. nausea / vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. What is your complexion before you fall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O normal complexion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O pale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O red</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. During, or just after the fall, do you experience any of the following complaints? (multiple answers possible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. loss of consciousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, how long does this last?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O less than 1 minute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 1-5 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O more than 5 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. convulsions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
c. stiffening/cramping of the body O yes O no O I do not know
d. urinary incontinence O yes O no O I do not know
e. fecal incontinence O yes O no O I do not know
b. biting of the tongue O yes O no O I do not know
g. inability to stand up after a fall O yes O no O I do not know
h. loss of strength or sensibility in the limbs O yes O no O I do not know
i. difficulty speaking O yes O no O I do not know
j. confusion O yes O no O I do not know
If yes, how long does this last?
O less than 1 minute
O 1-5 minutes
O more than 5 minutes

**Mobility before the (last) fall.**

12. Did you experience difficulty walking? O yes O no
13. Did you use a walking aid? O yes O no
If yes, what kind of aid(s)?
  O walking cane
  O wheelchair
  O tripod
  O scootmobil
  O rollator
  O Other: __________
14. Did you have a good balance? O yes O no
15. Did you experience pain in your legs or feet? O yes O no
16. Did you experience a decreased sensibility in your legs or feet? O yes O no
17. Did you have decreased strength in one or both legs? O yes O no
18. Did you experience joint stiffness? O yes O no
19. Before the fall, were you afraid to fall? (please tick the appropriate box below)
   [Not afraid] 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 [Very much afraid]
20. Are you afraid to fall? (please tick the appropriate box below)
   [Not afraid] 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 [Very much afraid]

**Osteoporosis.**
21. Did you sustain a fracture since your 50th birthday? O yes, namely: __________ O no
22. Do you have one or more collapsed vertebrae? O yes O no O I do not know
23. Did your mother ever break her hip? O yes O no O I do not know
24. Do you weigh less than 60 kilograms (women) or less than 67 kilograms (men)? O yes O no
25. Do you spend more than 20 hours a day in bed or lying on the couch?  
   O yes  O no

26. How often do you get outside?  
   O daily  
   O weekly  
   O monthly  
   O (almost) never

27. Do you use dairy products? (such as milk, cheese, or yoghurt)  
   O yes  O no
   If yes, how many glasses of milk/buttermilk per day?  _______ glasses per day
   How many slices of bread with cheese per day?  _______ slices per day
   How many bowls of yoghurt/custard per day?  _______ bowls per day

28. How often do you have physical exercise? (for example half an hour walking, cycling, or swimming)  
   O daily  
   O 3 times per week  
   O weekly  
   O monthly  
   O (almost) never

Eyesight / vision.
29. Can you read the newspaper well?  
   O yes  O no

30. Did you experience a marked decrease in eyesight over the past 6 months?  
   O yes  O no

31. Do you use an aid to increase your eyesight?  
   O yes  O no
   If yes, what type of aid? ____________________________________________

Urinary passages.
32. Do you have difficulty holding your water?  
   O yes  O no

33. At night, how many times do you have to get up to urinate? _____________________

Social situation.
34. Civil status  
   O married  
   O widow / widower  
   O divorced  
   O single  
   O living together with: ________________________
35. How do you live?  
O independently without help  
O independently with help (e.g. partner / homecare)  
O home for the elderly  
O nursing home

36. Since the fall, did you visit a physiotherapist?  
O yes  
O no

Is yes, how often do you visit the physiotherapist?  
______ times per week  
______ times in total

37. Did you visit your family doctor after you fell?  
O yes  
O no

If yes, how many times did you visit your family doctor?  
______ times

38. Did your family doctor visit you at home after you fell?  
O yes  
O no

If yes, how many times did your family doctor visit you at home?  
______ times

39. Do you smoke?  
O no  
O yes, namely:  ____ cigarettes per day

40. Do you drink alcohol?  
O no  
O yes, namely:  ____ glasses per day

41. During the past month, did you ever feel dejected, depressed, or desperate?  
O yes  
O no

42. During the past month, did experience a loss in interest in things?  
O yes  
O no

43. Please tick which of the following diseases you have been /are treated for:  
O diabetes mellitus  
O high blood pressure  
O stroke / cerebral infarction  
O heart attack  
O eye disorder  
O thyroid disease  
O cancer  
O other: ________________________

44. Which medicines do you use at the moment?  

<table>
<thead>
<tr>
<th>Name medicine</th>
<th>Dose</th>
<th>How often do you use this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(please continue on the back if necessary)

Thank you very much for answering this questionnaire!