Falling in the Netherlands: prevention, care, and follow-up of fall-related injury
Boele van Hensbroek, P.
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)
a. while getting up (from a bed or a chair) | O yes  | O no  | O I do not know
b. when turning your head or shaving     | O yes  | O no  | O I do not know
c. at night while getting out of bed    | O yes  | O no  | O I do not know
d. within 2 hours after a meal          | O yes  | O no  | O I do not know
e. while coughing of laughing           | O yes  | O no  | O I do not know
f. on the toilet while urinating or defecating | O yes  | O no  | O I do not know
g. in warm weather or a warm environment | O yes  | O no  | O I do not know
h. after prolonged standing              | O yes  | O no  | O I do not know
i. with emotional stress or pain         | O yes  | O no  | O I do not know
j. caused by an accident (e.g. slip or trip) | O yes  | O no  | O I do not know
k. while exercising                      | O yes  | O no  | O I do not know

9. Do you feel the fall coming up?    | O yes  | O no  | O I do not know
If yes, what are your complaints before you fall? (multiple answers possible)
   a. dizziness                         | O yes  | O no  | O I do not know
   b. black before eyes or light feeling in head | O yes  | O no  | O I do not know
c. heart palpitations                  | O yes  | O no  | O I do not know
d. chest pain                          | O yes  | O no  | O I do not know
e. tingling in the hands or around the mouth | O yes  | O no  | O I do not know
f. shortness of breath                  | O yes  | O no  | O I do not know
g. warm sensation in the belly          | O yes  | O no  | O I do not know
h. blurred vision / double-sight        | O yes  | O no  | O I do not know
i. headache                            | O yes  | O no  | O I do not know
j. transpire                           | O yes  | O no  | O I do not know
k. nausea / vomiting                    | O yes  | O no  | O I do not know

10. What is your complexion before you fall?  
   O normal complexion  
   O pale  
   O red  
   O unknown  

11. During, or just after the fall, do you experience any of the following complaints? (multiple answers possible)
   a. loss of consciousness    | 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
   b. convulsions | O yes  | O no  | O I do not know
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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
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<tr>
<td>c. stiffening/cramping of the body</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>d. urinary incontinence</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>e. fecal incontinence</td>
<td>O</td>
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<td>b. biting of the tongue</td>
<td>O</td>
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<td>g. inability to stand up after a fall</td>
<td>O</td>
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<td>O</td>
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<td>h. loss of strength or sensibility in the limbs</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>i. difficulty speaking</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>j. confusion</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>If yes, how long does this last?</td>
<td>O</td>
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<td>- more than 5 minutes</td>
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**Mobility before the (last) fall.**

12. Did you experience difficulty walking?                                 | O   | O   |
13. Did you use a walking aid?                                              | O   | O   |
If yes, what kind of aid(s)?
- walking cane
- wheelchair
- tripod
- scootmobil
- rollator
- Other: _____________

14. Did you have a good balance?                                            | O   | O   |
15. Did you experience pain in your legs or feet?                           | O   | O   |
16. Did you experience a decreased sensibility in your legs or feet?        | O   | O   |
17. Did you have decreased strength in one or both legs?                    | O   | O   |
18. Did you experience joint stiffness?                                     | O   | O   |

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   | O   |
22. Do you have one or more collapsed vertebrae?                            | O   | O   | O I don't know |
23. Did your mother ever break her hip?                                     | O   | O   | O I don't know |
24. Do you weigh less than 60 kilograms (women) or less than 67 kilograms (men)? | O   | O   |
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?

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<th>Dose</th>
<th>How often do you use this medicine?</th>
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(please continue on the back if necessary)

Thank you very much for answering this questionnaire!