TOOL:

Month-at-a-glance

Monthly reminders to help prevent falls

Year: _____

Monthly Reminders (check ✓ Y= Yes, N=No)	**Jan**		**Feb**		**Mar**		**Apr**		**May**		**Jun**		**Jul**		**Aug**		**Sep**		**Oct**		**Nov**		**Dec**	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Any changes in mobility or balance?																								
Any changes in comfort with daily tasks (e.g., bathing, toileting and moving around)?																								
Any difficulties taking medications correctly? Any new side effects?																								
Any changes in vision or hearing (e.g., squinting, struggling to hear)?																								
Are assistive devices comfortable to use? Working well?																								

Notes/observations:

Check in with your mental health. If you find yourself having more bad days than good days, reach out for support or call 9-8-8.