Five times Sit to Stand Test:

Method:
Use a straight back chair with a solid seat that is 16" high. Ask participant to sit on the chair with arms folded across their chest.

Instructions:
"Stand up and sit down as quickly as possible 5 times, keeping your arms folded across your chest."

Measurement:
Stop timing when the participant stands the 5th time.

Outcomes:

- (Guralnik 2000)
  Inability to rise from a chair five times in less than 13.6 seconds is associated with increased disability and morbidity

- (Buatois, et al., 2008)
  The optimal cutoff time for performing the FTSS test in predicting recurrent fallers was 15 seconds (sensitivity 55%, specificity 65%). 2,735 subjects aged 65 and older in an apparently good state of health were tested.

- (Bohannon, 2006)
  Metaanalysis results "demonstrated that individuals with times for 5 repetitions of this test exceeding the following can be considered to have worse than average performance" (Bohannon, 2006)
  - 60-69 y/o **11.4 sec**
  - 70-79 y/o **12.6 sec**
  - 80-89 y/o **14.8 sec**

References:

Guralnik, J. M., L. Ferrucci, et al. (2000). "Lower extremity function and subsequent disability: consistency across studies, predictive models, and value of gait speed alone compared with the short physical performance battery." *J Gerontol A Biol Sci Med Sci* 55(4): M221-31.

Buatois S, Miljkovic D, Manckoundia P, Gueguen R, Miget P, Vancon G et al. Five times sit to stand test is a predictor of recurrent falls in healthy community-living subjects aged 65 and older. *J Am Geriatr Soc* 2008; 56(8):1575-1577.

Bohannon RW. Reference values for the five-repetition sit-to-stand test: a descriptive metaanalysis of data from elders. *Percept Mot Skills* 2006; 103(1):215-222.

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0%	10	20	30	40	50	60	70	80	90	100%
No Confidence										Completely Confident

How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off of an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____% of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Berg Balance Scale

The Berg Balance Scale (BBS) was developed to measure balance among older people with impairment in balance function by assessing the performance of functional tasks. It is a valid instrument used for evaluation of the effectiveness of interventions and for quantitative descriptions of function in clinical practice and research. The BBS has been evaluated in several reliability studies. *A recent study of the BBS, which was completed in Finland, indicates that a change of eight (8) BBS points is required to reveal a genuine change in function between two assessments among older people who are dependent in ADL and living in residential care facilities.*

Description:
14-item scale designed to measure balance of the older adult in a clinical setting.

Equipment needed: Ruler, two standard chairs (one with arm rests, one without), footstool or step, stopwatch or wristwatch, 15 ft walkway

Completion:

Time: 15-20 minutes

Scoring: A five-point scale, ranging from 0-4. "0" indicates the lowest level of function and "4" the highest level of function. Total Score = 56

Interpretation:
41-56 = low fall risk
21-40 = medium fall risk
0 –20 = high fall risk

A change of 8 points is required to reveal a genuine change in function between 2 assessments.

Berg Balance Scale

Name: _____ Date: _____

Location: _____ Rater: _____

ITEM DESCRIPTION	SCORE (0-4)
Sitting to standing	_____
Standing unsupported	_____
Sitting unsupported	_____
Standing to sitting	_____
Transfers	_____
Standing with eyes closed	_____
Standing with feet together	_____
Reaching forward with outstretched arm	_____
Retrieving object from floor	_____
Turning to look behind	_____
Turning 360 degrees	_____
Placing alternate foot on stool	_____
Standing with one foot in front	_____
Standing on one foot	_____

Total _____

GENERAL INSTRUCTIONS

Please document each task and/or give instructions as written. When scoring, please record the lowest response category that applies for each item.

In most items, the subject is asked to maintain a given position for a specific time. Progressively more points are deducted if:

- the time or distance requirements are not met
- the subject's performance warrants supervision
- the subject touches an external support or receives assistance from the examiner

Subject should understand that they must maintain their balance while attempting the tasks. The choices of which leg to stand on or how far to reach are left to the subject. Poor judgment will adversely influence the performance and the scoring.

Equipment required for testing is a stopwatch or watch with a second hand, and a ruler or other indicator of 2, 5, and 10 inches. Chairs used during testing should be a reasonable height. Either a step or a stool of average step height may be used for item # 12.

Berg Balance Scale

SITTING TO STANDING
INSTRUCTIONS: Please stand up. Try not to use your hand for support.
( ) 4 able to stand without using hands and stabilize independently
( ) 3 able to stand independently using hands
( ) 2 able to stand using hands after several tries
( ) 1 needs minimal aid to stand or stabilize
( ) 0 needs moderate or maximal assist to stand

STANDING UNSUPPORTED
INSTRUCTIONS: Please stand for two minutes without holding on.
( ) 4 able to stand safely for 2 minutes
( ) 3 able to stand 2 minutes with supervision
( ) 2 able to stand 30 seconds unsupported
( ) 1 needs several tries to stand 30 seconds unsupported
( ) 0 unable to stand 30 seconds unsupported

If a subject is able to stand 2 minutes unsupported, score full points for sitting unsupported. Proceed to item #4.

SITTING WITH BACK UNSUPPORTED BUT FEET SUPPORTED ON FLOOR OR ON A STOOL
INSTRUCTIONS: Please sit with arms folded for 2 minutes.
( ) 4 able to sit safely and securely for 2 minutes
( ) 3 able to sit 2 minutes under supervision
( ) 2 able to able to sit 30 seconds
( ) 1 able to sit 10 seconds
( ) 0 unable to sit without support 10 seconds

STANDING TO SITTING
INSTRUCTIONS: Please sit down.
( ) 4 sits safely with minimal use of hands
( ) 3 controls descent by using hands
( ) 2 uses back of legs against chair to control descent
( ) 1 sits independently but has uncontrolled descent
( ) 0 needs assist to sit

TRANSFERS
INSTRUCTIONS: Arrange chair(s) for pivot transfer. Ask subject to transfer one way toward a seat with armrests and one way toward a seat without armrests. You may use two chairs (one with and one without armrests) or a bed and a chair.
( ) 4 able to transfer safely with minor use of hands
( ) 3 able to transfer safely definite need of hands
( ) 2 able to transfer with verbal cuing and/or supervision
( ) 1 needs one person to assist
( ) 0 needs two people to assist or supervise to be safe

STANDING UNSUPPORTED WITH EYES CLOSED
INSTRUCTIONS: Please close your eyes and stand still for 10 seconds.
( ) 4 able to stand 10 seconds safely
( ) 3 able to stand 10 seconds with supervision
( ) 2 able to stand 3 seconds
( ) 1 unable to keep eyes closed 3 seconds but stays safely
( ) 0 needs help to keep from falling

STANDING UNSUPPORTED WITH FEET TOGETHER
INSTRUCTIONS: Place your feet together and stand without holding on.
( ) 4 able to place feet together independently and stand 1 minute safely
( ) 3 able to place feet together independently and stand 1 minute with supervision
( ) 2 able to place feet together independently but unable to hold for 30 seconds
( ) 1 needs help to attain position but able to stand 15 seconds feet together
( ) 0 needs help to attain position and unable to hold for 15 seconds

Berg Balance Scale continued…

REACHING FORWARD WITH OUTSTRETCHED ARM WHILE STANDING
INSTRUCTIONS: Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at the end of fingertips when arm is at 90 degrees. Fingers should not touch the ruler while reaching forward. The recorded measure is the distance forward that the fingers reach while the subject is in the most forward lean position. When possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)
( ) 4 can reach forward confidently 25 cm (10 inches)
( ) 3 can reach forward 12 cm (5 inches)
( ) 2 can reach forward 5 cm (2 inches)
( ) 1 reaches forward but needs supervision
( ) 0 loses balance while trying/requires external support

PICK UP OBJECT FROM THE FLOOR FROM A STANDING POSITION
INSTRUCTIONS: Pick up the shoe/slipper, which is in front of your feet.
( ) 4 able to pick up slipper safely and easily
( ) 3 able to pick up slipper but needs supervision
( ) 2 unable to pick up but reaches 2-5 cm(1-2 inches) from slipper and keeps balance independently
( ) 1 unable to pick up and needs supervision while trying
( ) 0 unable to try/needs assist to keep from losing balance or falling

TURNING TO LOOK BEHIND OVER LEFT AND RIGHT SHOULDERS WHILE STANDING
INSTRUCTIONS: Turn to look directly behind you over toward the left shoulder. Repeat to the right. (Examiner may pick an object to look at directly behind the subject to encourage a better twist turn.)
( ) 4 looks behind from both sides and weight shifts well
( ) 3 looks behind one side only other side shows less weight shift
( ) 2 turns sideways only but maintains balance
( ) 1 needs supervision when turning
( ) 0 needs assist to keep from losing balance or falling

TURN 360 DEGREES
INSTRUCTIONS: Turn completely around in a full circle. Pause. Then turn a full circle in the other direction.
( ) 4 able to turn 360 degrees safely in 4 seconds or less
( ) 3 able to turn 360 degrees safely one side only 4 seconds or less
( ) 2 able to turn 360 degrees safely but slowly
( ) 1 needs close supervision or verbal cuing
( ) 0 needs assistance while turning

PLACE ALTERNATE FOOT ON STEP OR STOOL WHILE STANDING UNSUPPORTED
INSTRUCTIONS: Place each foot alternately on the step/stool. Continue until each foot has touched the step/stool four times.
( ) 4 able to stand independently and safely and complete 8 steps in 20 seconds
( ) 3 able to stand independently and complete 8 steps in > 20 seconds
( ) 2 able to complete 4 steps without aid with supervision
( ) 1 able to complete > 2 steps needs minimal assist
( ) 0 needs assistance to keep from falling/unable to try

STANDING UNSUPPORTED ONE FOOT IN FRONT
INSTRUCTIONS: (DEMONSTRATE TO SUBJECT) Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot. (To score 3 points, the length of the step should exceed the length of the other foot and the width of the stance should approximate the subject's normal stride width.)
( ) 4 able to place foot tandem independently and hold 30 seconds
( ) 3 able to place foot ahead independently and hold 30 seconds
( ) 2 able to take small step independently and hold 30 seconds
( ) 1 needs help to step but can hold 15 seconds
( ) 0 loses balance while stepping or standing

STANDING ON ONE LEG
INSTRUCTIONS: Stand on one leg as long as you can without holding on.
( ) 4 able to lift leg independently and hold > 10 seconds
( ) 3 able to lift leg independently and hold 5-10 seconds
( ) 2 able to lift leg independently and hold ≥ 3 seconds
( ) 1 tries to lift leg unable to hold 3 seconds but remains standing independently.
( ) 0 unable to try of needs assist to prevent fall

( ) TOTAL SCORE (Maximum = 56)

Dynamic Gait Index
Scoring Form

1. Gait Level Surface

Instructions: Walk at your normal pace from here to the next mark (20 feet).
Grading: Mark the lowest category that applies.

_____(3) Normal: Walks 20', no assistive devices, good speed, no evidence of imbalance, normal gait pattern.

_____(2) Mild Impairment: Walks 20', uses assistive devices, slower speed, mild gait deviations.

_____(1) Moderate Impairment: Walks 20', slow speed, abnormal gait pattern, evidence of imbalance.

_____(0) Severe Impairment: Walks 20' without assistance, severe gait deviations or imbalance.

2. Change in Gait Speed

Instructions: Begin walking at your normal pace (for 5 feet), when I tell you 'go', walk as fast as you can (for 5 feet). When I tell you 'slow', walk as slowly as you can (for 5 feet).
Grading: Mark the lowest category that applies.

_____(3) Normal: Changes walking speed smoothly without loss of balance or gait deviation. Shows a significant difference in walking speeds between normal, fast, and slow.

_____(2) Mild Impairment: Changes speed but demonstrates mild gait deviations, or no gait deviations but unable to achieve a significant change in velocity, or uses an assistive device.

_____(1) Moderate Impairment: Makes only minor adjustments to walking speed, or accomplishes a change in speed with significant gait deviations, or changes speed but loses significant gait deviations, or changes speed but loses balance but is able to recover and continue walking.

_____(0) Severe Impairment: Unable to change speeds, or loses balance and has to reach for wall or be caught.

3. Gait with Horizontal Head Turns

Instructions: Begin walking at your normal pace. When I tell you 'look right', keep walking straight and turn your head to the right. Keep looking to the right until I tell you 'look left', then keep walking straight and turn your head to the left. Keep your head to the left until I tell you 'look straight', then keep walking straight but return your head to the center.
Grading: Mark the lowest category that applies.

_____(3) Normal: Turns head smoothly with no change in gait.

_____(2) Mild Impairment: Turns head smoothly with slight change in gait, i.e. minor disruption to smooth gait path, or uses walking aid.

_____(1) Moderate Impairment: Turns head smoothly with moderate change in gait, i.e. slows down, staggers but recovers, can continue to walk.

_____(0) Severe Impairment: Turns head smoothly with severe disruption of gait, i.e. staggers outside 15" path, loses balance, stops, reaches for wall.

*Reproducible Master Scoring Form accompanying VHI's **"Administering Functional Assessment Tests"** DVD #2.*

4. Gait with Vertical Head Turns

Instructions: Begin walking at your normal pace. When I tell you 'look up', keep walking straight and tilt your head up. Keep looking up until I tell you 'look down', then keep walking straight and tilt your head down. Keep looking down until I tell you 'look straight', then keep walking straight and return your head to the center.
Grading: Mark the lowest category that applies.

_____(3) Normal: Performs head turns with no change in gait.

_____(2) Mild Impairment: Performs head turns with slight change in gait, i.e. minor disruption to smooth gait path or uses walking aid.

_____(1) Moderate Impairment: Performs head turns with moderate change in gait, i.e. slows down, staggers but recovers, can continue to walk.

_____(0) Severe Impairment: Performs head turns with severe disruption of gait, i.e. staggers outside a 15" path, loses balance, reaches for wall.

5. Gait and Pivot Turn

Instructions: Begin walking at your normal pace. When I tell you 'turn and stop', turn as quickly as you can to face the opposite direction and stop.
Grading: Mark the lowest category that applies.

_____(3) Normal: Pivot turns safely within 3 seconds and stops quickly with no loss of balance.

_____(2) Mild Impairment: Pivot turns safely in over 3 seconds and stops with no loss in balance.

_____(1) Moderate Impairment: Pivot turns slowly, requires verbal cueing, requires several small steps to catch balance following turn and stop.

_____(0) Severe Impairment: Cannot pivot turn safely, requires assistance to turn and stop.

6. Step Over Obstacle

Instructions: Begin walking at your normal pace. When you come to the obstacle, step over it, not around it, and continue walking.
Grading: Mark the lowest category that applies.

_____(3) Normal: Steps over box without changing gait, no evidence of imbalance.

_____(2) Mild Impairment: Steps over box, but must slow down and adjust steps to clear box safely.

_____(1) Moderate Impairment: Steps over box, but must stop before stepping over. May require verbal cueing.

_____(0) Severe Impairment: Cannot step over box without assistance.

7. Step Around Obstacles

Instructions: Begin walking at a normal speed. When you come to the first cone (about 6 feet away), walk around it on the right side. When you come to the second cone (6 feet past first one), walk around it on the left.
Grading: Mark the lowest category that applies.

_____(3) Normal: Walks around cones safely without changing gait, no evidence of imbalance.

_____(2) Mild Impairment: Walks around both cones, but must slow down and adjust gait to clear cones.

_____(1) Moderate Impairment: Walks around both cones, but must significantly slow gait or requires verbal cueing.

_____(0) Severe Impairment: Unable to clear cones, walks into one or both, or requires physical assistance.

8. Steps

Instructions: Walk up these stairs as you would at home (i.e. using the rail if necessary). At the top, turn around and come down.
Grading: Mark the lowest category that applies:

_____(3) Normal: Alternates feet, no rail.

_____(2) Mild Impairment: Alternates feet, must use rail.

_____(1) Moderate Impairment: Two feet to a stair, must use rail.

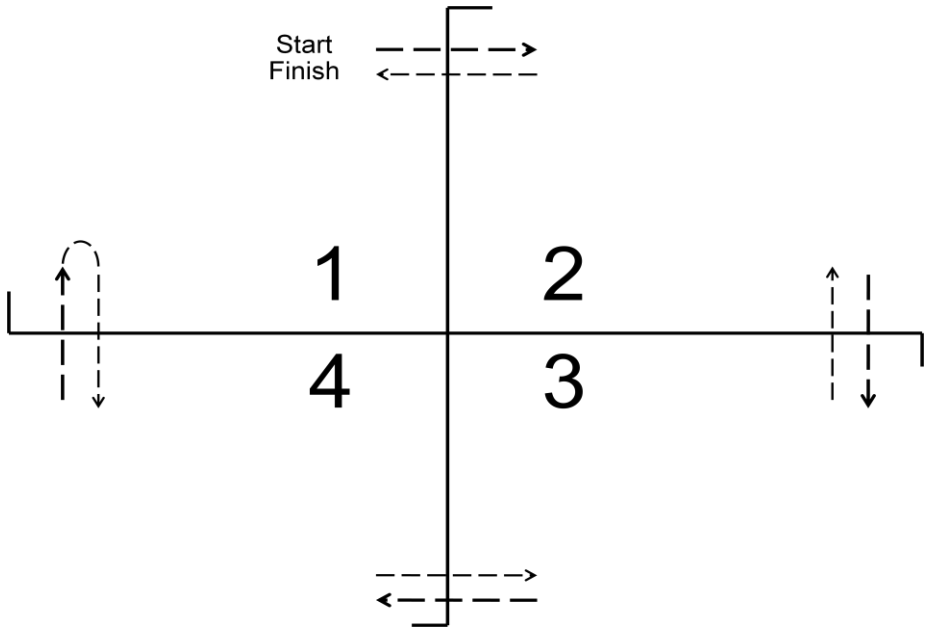
_____(0) Severe Impairment: Cannot do safely.

Four Step Square Test Instructions

General Information:

- The patient is instructed to stand in square 1 facing square number 2 (see figure below)
- The patient is required to step as fast as possible into each square in the following sequence: 2, 3, 4, 1, 4, 3, 2, and 1
    - requires the patient to step forward, backward, and sideway to the right and left
- Equipment required for the FSST includes a stopwatch and 4 canes.

Set-up (derived from Dite and Temple 2002): A square is formed with the 4 canes by resting them flat on the floor.



Patient Instructions (derived from Dite and Temple 2002):

- "Try to complete the sequence as fast as possible without touching the sticks. Both feet must make contact with the floor in each square. If possible, face forward during the entire sequence."
- Demonstrate the sequence to the patient.
- Ask the patient to complete one practice trial to ensure the patient knows the sequence. Repeat the trial if the patient is unsuccessful

at completing the sequence, loses balance, or contacts a cane during the trial.
- Two FSST are completed with the best time taken as the score.
- A score is still provided if the patient is unable to face forward during the entire sequence.

Scoring:

- the best time of two FSST is the score
- stopwatch starts when the first foot contacts the floor in square 2
- stopwatch finishes when the last foot comes back to touch the floor in square 1

Four Step Square Test (FSST)

Name:_____

Assistive Device and/or Bracing Used:_____

Date:_____

Trial 1_____sec.___ Trial 1_____sec.___

FSST Score (best timed trial):_____sec.___

Date:_____

Trial 1_____sec.___ Trial 1_____sec.___

FSST Score (best timed trial):_____sec.___

Date:_____

Trial 1_____sec.___ Trial 1_____sec.___

FSST Score (best timed trial):_____sec.___

Date:_____

Trial 1_____sec.___ Trial 1_____sec.___

FSST Score (best timed trial):_____sec.___

References:

Dite, W. and Temple, V. A. (2002). "A clinical test of stepping and change of direction to identify multiple falling older adults." Arch Phys Med Rehabil **83**(11): 1566-1571.

Functional Reach Test and

Modified Functional Reach Instructions

General Information: The Functional Reach test can be administered while the patient is standing (Functional Reach) or sitting (Modified Functional Reach).

Functional Reach (standing instructions):

- The patient is instructed to next to, but not touching, a wall and position the arm that is closer to the wall at 90 degrees of shoulder flexion with a closed fist.
- The assessor records the starting position at the 3rd metacarpal head on the yardstick.
- Instruct the patient to “Reach as far as you can forward without taking a step.”
- The location of the 3rd metacarpal is recorded.
- Scores are determined by assessing the difference between the start and end position is the reach distance, usually measured in inches.
- Three trials are done and the average of the last two is noted.

Modified Functional Reach Test (Adapted for individuals who are unable to stand):

- Performed with a leveled yardstick that has been mounted on the wall at the height of the patient’s acromion level in the non-affected arm while sitting in a chair
- Hips, knees and ankles positioned are at 90 degree of flexion, with feet positioned flat on the floor.
- The initial reach is measured with the patient sitting against the back of the chair with the upper-extremity flexed to 90 degrees, measure was taken from the distal end of the third metacarpal along the yardstick.
- Consists of three conditions over three trials
    - Sitting with the unaffected side near the wall and leaning forward
    - Sitting with the back to the wall and leaning right
    - Sitting with the back to the wall leaning left.

- Instructions should include leaning as far as possible in each direction without rotation and without touching the wall
- Record the distance in centimeters covered in each direction
- If the patient is unable to raise the affected arm, the distance covered by the acromion during leaning is recorded
- First trial in each direction is a practice trial and should not included in the final result
- A 15 second rest break should be allowed between trials

Set-up:

- A yardstick and duck tap will be needed for the assessment.
- The yardstick should be affixed to the wall at the level of the patient's acromion.

References:

Duncan, P. W., D. K. Weiner, et al. (1990). "Functional reach: a new clinical measure of balance." J Gerontol **45**(6): M192-197.

Katz-Leurer, M., I. Fisher, et al. (2009). "Reliability and validity of the modified functional reach test at the sub-acute stage post-stroke." Disabil Rehabil **31**(3): 243-248.

Weiner, D. K., D. R. Bongiorni, et al. (1993). "Does functional reach improve with rehabilitation?" Arch Phys Med Rehabil **74**(8): 796-800.

Weiner, D. K., P. W. Duncan, et al. (1992). "Functional reach: a marker of physical frailty." J Am Geriatr Soc **40**(3): 203-207.

Functional Reach Test and

Modified Functional Reach Score Sheet

Name:_____

Instructions:

Instruct the patient to “Reach as far as you can forward without taking a step”

Score Sheet:

Date	Trial One (Practice)	Trial Two	Trial Three	**Total (average of trial 2 and 3 only)**

Falls Efficacy Scale

Name:_____ Date:_____

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity:	**Score:** 1 = very confident 10 = not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off of the toilet	
Total Score	

A total score of greater than 70 indicates that the person has a fear of falling

Adapted from Tinetti et al (1990)

References:

Tinetti, M., D. Richman, et al. (1990). "Falls efficacy as a measure of fear of falling." Journal of gerontology **45**(6): P239.

TINETTI BALANCE ASSESSMENT TOOL

Tinetti ME, Williams TF, Mayewski R, Fall Risk Index for elderly patients based on number of chronic disabilities. Am J Med 1986:80:429-434

PATIENTS NAME _____ D.o.b. _____ Ward _____

BALANCE SECTION

Patient is seated in hard, armless chair;

		Date		
Sitting Balance	Leans or slides in chair Steady, safe	= 0 = 1		
Rises from chair	Unable to without help Able, uses arms to help Able without use of arms	= 0 = 1 = 2		
Attempts to rise	Unable to without help Able, requires > 1 attempt Able to rise, 1 attempt	= 0 = 1 = 2		
Immediate standing Balance (first 5 seconds)	Unsteady (staggers, moves feet, trunk sway) Steady but uses walker or other support Steady without walker or other support	= 0 = 1 = 2		
Standing balance	Unsteady Steady but wide stance and uses support Narrow stance without support	= 0 = 1 = 2		
Nudged	Begins to fall Staggers, grabs, catches self Steady	= 0 = 1 = 2		
Eyes closed	Unsteady Steady	= 0 = 1		
Turning 360 degrees	Discontinuous steps Continuous	= 0 = 1		
	Unsteady (grabs, staggers) Steady	= 0 = 1		
Sitting down	Unsafe (misjudged distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	= 0 = 1 = 2		
	Balance score		/16	/16

P.T.O.

TINETTI BALANCE ASSESSMENT TOOL

GAIT SECTION

Patient stands with therapist, walks across room (+/- aids), first at usual pace, then at rapid pace.

		Date		
Indication of gait (Immediately after told to 'go'.)	Any hesitancy or multiple attempts No hesitancy	= 0 = 1		
Step length and height	Step to Step through R Step through L	= 0 = 1 = 1		
Foot clearance	Foot drop L foot clears floor R foot clears floor	= 0 = 1 = 1		
Step symmetry	Right and left step length not equal Right and left step length appear equal	= 0 = 1		
Step continuity	Stopping or discontinuity between steps Steps appear continuous	= 0 = 1		
Path	Marked deviation Mild/moderate deviation or uses w. aid Straight without w. aid	= 0 = 1 = 2		
Trunk	Marked sway or uses w. aid No sway but flex. knees or back or uses arms for stability No sway, flex., use of arms or w. aid	= 0 = 1 = 2		
Walking time	Heels apart Heels almost touching while walking	= 0 = 1		
	Gait score		/12	/12
Balance score carried forward			/16	/16
Total Score = Balance + Gait score			/28	/28

Risk Indicators:

Tinetti Tool Score	Risk of Falls
≤18	High
19-23	Moderate
≥24	Low

Timed Up and Go Instructions

General Information (derived from Podsiadlo and Richardson, 1991):

- The patient should sit on a standard armchair, placing his/her back against the chair and resting his/her arms chair's arms. Any assistive device used for walking should be nearby.
- Regular footwear and customary walking aids should be used.
- The patient should walk to a line that is 3 meters (9.8 feet) away, turn around at the line, walk back to the chair, and sit down.
- The test ends when the patient's buttocks touch the seat.
- Patients should be instructed to use a comfortable and safe walking speed.
- A stopwatch should be used to time the test (in seconds).

Set-up:

- Measure and mark a 3 meter (9.8 feet) walkway
- Place a standard height chair (seat height 46cm, arm height 67cm) at the beginning of the walkway

Patient Instructions (derived from Podsiadlo and Richardson, 1991):

- Instruct the patient to sit on the chair and place his/her back against the chair and rest his/her arms chair's arms.
- The upper extremities should not be on the assistive device (if used for walking), but it should be nearby.
- Demonstrate the test to the patient.
- When the patient is ready, say "Go"
- The stopwatch should start when you say go, and should be stopped with the patient's buttocks touch the seat.

Timed Up and Go Testing Form

Name:_____

Assistive Device and/or Bracing Used:_____

Date:_____

TUG Time:_____

Date:_____

TUG Time:_____

Date:_____

TUG Time:_____

Date:_____

TUG Time:_____

Date:_____

TUG Time:_____

Reference:

Podsiadlo, D. and Richardson, S. (1991). "The timed "Up & Go": a test of basic functional mobility for frail elderly persons." J Am Geriatr Soc 39(2): 142-148.