

September 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell						

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

October 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
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28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell			

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November 2012

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December 2012

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2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
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January 2013

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6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
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					1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
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March 2013

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					1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
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July 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell			

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

August 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

September 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell					

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

October 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell		

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

November 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

December 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell				

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

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Thank you!

Name: _____

January 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	29 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	30 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	31 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

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- Fell and hit an object like a chair or stair

At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____

February 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
2 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	3 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	4 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	5 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	6 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	7 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	8 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
9 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	10 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	11 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	12 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	13 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	14 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	15 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
16 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	17 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	18 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	19 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	20 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	21 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	22 <input type="radio"/> No fall <input type="radio"/> Yes, I fell
23 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	24 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	25 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	26 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	27 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	28 <input type="radio"/> No fall <input type="radio"/> Yes, I fell	

Instructions:

At the **end of each day**, please fill in one circle for that date to indicate if you had a fall (*Yes, I fell*) or not (*No fall*).

Please mark "Yes, I fell" if you:

- Fell all the way to the floor or the ground, or
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At the **end of each month**, write your name, tear off the page for that month, and mail to WHI in the envelope provided. Before mailing, please review and make sure that each day has a mark indicating either *No fall* or *Yes, I fell*. Be sure to mail back the calendar page, even if you did not have any falls.

Thank you!

Name: _____