

Balance and Dizziness Questionnaire

Please fill out the entire questionnaire to the best of your ability. We realize the form is long, but because balance problems and dizziness can be related to so many different diagnoses, we need to gain as much information as possible during your initial visit, so that we may spend as much time as possible helping you with your problem.

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Medical History: Have you ever been diagnosed with any of the following conditions? Check all that apply: **X**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Back pain         |
| <input type="checkbox"/> Stroke  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck pain         |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Chemical dependency   | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Leg injuries  | <input type="checkbox"/> Vision problems     | <input type="checkbox"/> Ear problems      |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Migraine            | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Polio/Post polio syndrome   |  | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Neuropathy (sensation problem)                                      |  | <input type="checkbox"/> Head Trauma       |
| <input type="checkbox"/> Parkinson's disease   |  | <input type="checkbox"/> Meniere's disease |
| <input type="checkbox"/> Total Joint Replacement: (circle): knee    hip    shoulder    ankle |  |  |
| <input type="checkbox"/> Other condition _____   |  |  |

Do you currently experience any of these symptoms in your legs or feet?

pain     numbness     tingling     swelling

Do you use eyeglasses or contact lenses? YES or NO

Do you use a cane or walker? YES or NO

Do you wear hearing aids? YES or NO

Do you or did you use alcohol? YES or NO How much? \_\_\_\_\_

How many cups of caffeinated drink per day? (coffee, tea, soda) \_\_\_\_\_

Have you ever had drug therapy for cancer or intravenous antibiotics? Y or N

Have you fallen in the past year? YES or NO How many times? \_\_\_\_\_  
Please describe the reason for the falls: e.g. tripped on rug in dark room

Did you have an injury from falling which required medical care? If so, please describe:

List all medications you are currently taking, including over-the-counter medications:

Name of medication/ dose

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How would you describe your dizziness or balance problem? Grade the severity of the symptom by entering a number from 2 (marked), 1 (moderate), to 0 (none). Enter 0 if you do not have the symptom.

- A. Sensation of imbalance: \_\_\_\_\_ trouble walking  
\_\_\_\_\_ poor balance  
\_\_\_\_\_ falls
- B. Sense of movement of one's own body or the environment:  
\_\_\_\_\_ rotation (spinning, tumbling)  
\_\_\_\_\_ linear movement or pulling  
\_\_\_\_\_ tilting
- C. Sensations not associated with movement of the environment:  
\_\_\_\_\_ lightheadedness or faintness  
\_\_\_\_\_ floating  
\_\_\_\_\_ swimming  
\_\_\_\_\_ giddiness  
\_\_\_\_\_ rocking  
\_\_\_\_\_ spinning **inside** the head  
\_\_\_\_\_ fear or avoidance of being in public places
- D. Associated Symptoms: \_\_\_\_\_ sweating  
\_\_\_\_\_ nausea  
\_\_\_\_\_ vomiting  
\_\_\_\_\_ queasiness  
\_\_\_\_\_ tinnitus (ringing in the ears)
- E. Impaired Vision: \_\_\_\_\_ double vision  
\_\_\_\_\_ blurred vision  
\_\_\_\_\_ flashes of light  
\_\_\_\_\_ jumping of vision while walking or in car

Please describe in detail the circumstances and date when the problem began and what were your **initial** symptoms and problems. Was there any stress or anxiety around the time of onset?

If you have spells, please describe a typical spell in as much detail as possible and describe the frequency and duration of the spells:

To what extent is your dizziness or imbalance brought on by:  
(check one for each answer)            None            Some            Severely

Turning over in bed, bending over	_____	_____	_____
Looking up	_____	_____	_____
Standing up	_____	_____	_____
Rapid head movements	_____	_____	_____
Walking in a dark room	_____	_____	_____
Walking on uneven surfaces	_____	_____	_____
Loud noises	_____	_____	_____
Cough, sneeze, strain, laugh or blowing up balloons	_____	_____	_____
Movement of objects around you	_____	_____	_____
Moving your eyes while your head is still	_____	_____	_____
Wide open spaces	_____	_____	_____
Tunnels, bridges, supermarkets	_____	_____	_____
Elevators or escalators	_____	_____	_____
Menstrual periods	_____	_____	_____

Have you had: Evaluation by a neurologist? YES or NO  
 Evaluation by an eye doctor? YES or NO  
 Evaluation by an ear doctor ? YES or NO  
 Caloric test(water or air in ear)? YES or NO  
 MRI YES or NO (& was dye given by injection?) YES or NO

**Current Functional Status**

Are you independent in self care activities?            YES    NO  
 Are you working? YES    NO    Occupation \_\_\_\_\_  
 Can you drive in the daytime? YES    NO    Nighttime?    YES    NO  
 Are you able to:  
   Watch TV comfortably?    YES    NO  
   Read?                            YES    NO  
   Go Shopping?                YES    NO  
   Be in traffic?                 YES    NO  
   Use a computer?             YES    NO

Other activities you have difficulty with? \_\_\_\_\_

## The Activities-Specific Balance Confidence (ABC) Scale

Name: \_\_\_\_\_ Date: \_\_\_\_\_

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale from 0% to 100%. 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. 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 have any questions about answering any of these items, please ask your therapist.

**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 of 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 an escalator while holding onto parcels such that you cannot hold onto the railing? \_\_\_\_\_%
15. walk outside on icy sidewalks? \_\_\_\_\_%