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Rehabilitation Services

BALANCE QUESTIONNAIRE

Date: _____

Specifically, do you experience spells of vertigo (i.e. a sense of spinning)? ☐ Yes ☐ No
If yes, how long do these spells last? _____
When was the last time the vertigo occurred? _____
Is the vertigo:

Spontaneous	☐ Yes ☐ No
Induced by motion	☐ Yes ☐ No
Induced by position changes	☐ Yes ☐ No

Do you experience a sense of being off-balance (disequilibrium)? ☐ Yes ☐ No
If yes, is the feeling of being off balance:

Constant	☐ Yes ☐ No
Spontaneous	☐ Yes ☐ No
Induced by motion	☐ Yes ☐ No
Induced by position changes	☐ Yes ☐ No
Worse with fatigue	☐ Yes ☐ No
Worse outside	☐ Yes ☐ No
Worse in the dark	☐ Yes ☐ No
Worse on uneven surfaces	☐ Yes ☐ No

Does the feeling of being off balance occur when:

Lying down	☐ Yes ☐ No
Sitting	☐ Yes ☐ No
Standing	☐ Yes ☐ No
Walking	☐ Yes ☐ No

Do you or have you fallen (to the ground)? ☐ Yes ☐ No
If yes, please describe: _____
How often do you fall? _____
Do you stumble, stagger, or side-step while walking? ☐ Yes ☐ No
Do you drift to one side while you walk? ☐ Yes ☐ No
If yes, to which side do you drift? _____

What are your goals with physical therapy? _____
_____
_____

Pertinent past medical history:
Do you have:

☐ Diabetes	☐ Heart Disease	☐ Weakness or Paralysis
☐ High Blood Pressure	☐ Headaches	☐ Hearing Problems
☐ Arthritis	☐ Neck Problems	☐ Visual Problems
☐ Back Problems	☐ Lung Problems	☐ Memory Problems

(Please complete other side →)

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DIZZINESS HANDICAP INVENTORY

Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes," "No," or "Sometimes" to each question. ***Answer each question as it pertains to your dizziness or unsteadiness problem only. Please circle one.***

Y	S	N	P1. Does looking up increase your problem?
Y	S	N	E2. Because of your problem, do you feel frustrated?
Y	S	N	F3. Because of your problem, do you restrict your travel for business or recreation?
Y	S	N	P4. Does walking down an aisle of a supermarket increase your problem?
Y	S	N	F5. Because of your problem, do you have difficulty getting into or out of bed?
Y	S	N	F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or going to parties?
Y	S	N	F7. Because of your problem, do you have difficulty reading?
Y	S	N	P8. Does performing more ambitious activities, like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem?
Y	S	N	E9. Because of your problem are you afraid to leave your home without having someone accompany you?
Y	S	N	E10. Because of your problem, have you been embarrassed in front of others?
Y	S	N	P11. Do quick movements of your head increase your problems?
Y	S	N	F12. Because of your problem, do you avoid heights?
Y	S	N	P13. Does turning over in bed increase your problem?
Y	S	N	F14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?
Y	S	N	E15. Because of your problem, are you afraid people may think you are intoxicated?
Y	S	N	F16. Because of your problem, is it difficult for you to go for a walk by yourself?
Y	S	N	P17. Does walking down a sidewalk increase your problem?
Y	S	N	E18. Because of your problem, is it difficult for you to concentrate?
Y	S	N	F19. Because of your problem, is it difficult for you to walk around your house in the dark?
Y	S	N	E20. Because of your problem, are you afraid to stay at home alone?
Y	S	N	E21. Because of your problem, do you feel handicapped?
Y	S	N	E22. Has your problem placed stress on your relationships with members of your family or friends?
Y	S	N	E23. Because of your problem, are you depressed?
Y	S	N	F24. Does your problem interfere with your job or household responsibilities?
Y	S	N	P25. Does bending over increase your problem?

(Please complete other side →)