



**Balance/ Vestibular Intake Form**



Name:

Date:

Occupation:

Full-time     Part-time     Other

**Primary Concern/ Reason for Visit:**

**Symptoms** (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Light Headedness      | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Disorientation            |
| <input type="checkbox"/> Spinning              | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Difficulty with Memory    |
| <input type="checkbox"/> Rocking/ Swaying      | <input type="checkbox"/> Facial Numbness     | <input type="checkbox"/> Hearing loss              |
| <input type="checkbox"/> Balance Difficulty    | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Tinnitus (ringing in ear) |
| <input type="checkbox"/> Passing out/ Fainting | <input type="checkbox"/> Fatigue/ Weakness   | <input type="checkbox"/> Ear fullness/ pressure    |
| <input type="checkbox"/> Other                 |  |  |

How often do symptoms occur?

- Daily     Weekly     Constantly

How long do symptoms last?

- Seconds     Minutes     Hours     Days

Symptoms increase with (check all that apply):

- |   |  |                                      |  |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> Rolling in bed | <input type="checkbox"/> Turning head    | <input type="checkbox"/> Crowds      | <input type="checkbox"/> Bearing down/ straining |
| <input type="checkbox"/> Lying to sit   | <input type="checkbox"/> Looking up/down | <input type="checkbox"/> Driving     | <input type="checkbox"/> Cough/ sneeze           |
| <input type="checkbox"/> Sit to stand   | <input type="checkbox"/> Bending over    | <input type="checkbox"/> Reading     | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Lying down     | <input type="checkbox"/> Walking         | <input type="checkbox"/> Loud noises |  |

**History of Falls?**

- Yes     No

If yes, how often?

- Daily     Weekly     Monthly     Yearly

If yes, please describe how your last fall occurred:

Do you find yourself bumping into walls or furniture, tripping over obstacles, or drifting to one side when you walk?

- Yes     No



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

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale (0-100). 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 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%
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**No confidence**  
(i.e. will lose balance)

**Completely confident**  
(i.e. will not lose balance)

“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 tiptoes 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 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? \_\_\_\_\_%



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### The Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate your answer by checking “yes”, “sometimes”, or “no” for each question. Answer each question only as it pertains to your dizziness or unsteadiness problem.

	Questions	Yes	Sometimes	No
P1.	Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E2.	Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3.	Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4.	Does walking down the aisle of a supermarket increase your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5.	Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6.	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, or going to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7.	Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8.	Does performing more ambitious activities such as sports, dancing, household chores (sweeping, or putting away dishes) increase your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10.	Because of your problem have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Questions	Yes	Sometimes	No
P11.	Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12.	Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13.	Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14.	Because of your problem, is it difficult for you to do strenuous homework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E15.	Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P17.	Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E18.	Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19.	Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20.	Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E21.	Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22.	Has the problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23.	Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24.	Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P25.	Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>