SCOTTSDALE EAR, NOSE & THROAT

Balance/ Vestibular Intake Form

VALLEY ENT
superior medical care, right in your neighborhood

Name: Date:

Occupation: ☐Full-time ☐Part-time ☐Other

Primary Concern/ Reason for Visit:

When was the first time you experienced dizziness? _____

When was the most recent episode of dizziness? _____

What were the circumstances? _____

Symptoms (check all that apply):

☐ Light Headedness	☐ Visual Disturbances	☐ Disorientation
☐ Spinning	☐ Light Sensitivity	☐ Difficulty with Memory
☐ Rocking/ Swaying	☐ Headaches	☐ Hearing loss
☐ Balance Difficulty	☐ Facial Numbness	☐ Tinnitus (ringing in ear)
☐ Passing out/ Fainting	☐ Fatigue/ Weakness	☐ Ear fullness/ pressure
☐ Motion Sickness	☐ Brain Fog	☐ Sound Sensitivity
☐ Nausea	☐ Other	

How often do symptoms occur?
☐ Daily ☐ Weekly ☐ Constantly

How long do symptoms last?
☐ Seconds ☐ Minutes ☐ Hours ☐ Days

About how many episodes (if any) have you experienced? _____

Symptoms increase with (check all that apply):

☐ Rolling in bed	☐ Turning head	☐ Crowds	☐ Bearing down/ straining
☐ Lying to sit	☐ Looking up/down	☐ Driving	☐ Cough/ sneeze
☐ Sit to stand	☐ Bending over	☐ Reading	☐ Other
☐ Lying down	☐ Walking	☐ Loud noises	

History of Falls?
☐ Yes ☐ No

If yes, how often?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

About how many falls (if any) have you experienced? _____

What were the circumstances? _____

Name:
Date:

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%**

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? _____%

Name:
Date:

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?	☐	☐	☐
E2.	Because of your problem, do you feel frustrated?	☐	☐	☐
F3.	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
P4.	Does walking down the aisle of a supermarket increase your problems?	☐	☐	☐
F5.	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
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?	☐	☐	☐
F7.	Because of your problem, do you have difficulty reading?	☐	☐	☐
P8.	Does performing more ambitious activities such as sports, dancing, household chores (sweeping, or putting away dishes) increase your problems?	☐	☐	☐
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10.	Because of your problem have you been embarrassed in front of others?	☐	☐	☐

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