Vestibular Questionnaire

1. Please describe the MAJOR problem or reason you are seeing us here today:
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2. Please describe, in detail, the circumstances (and date if possible) when your problem began:
____
____
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3. Please rate, on a scale of 1 (little problem) to 10 (worst possible) how limiting this problem is:
Today: ____/10 At worst_____/10

4. Are the symptoms constant (Y /N) or do they come in spells (Y /N)? If you have spells, please describe a typical spell in as much detail as possible (quality, frequency, duration and triggers)?
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____
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5. Please characterize your problem:

○ Sense of spinning	○ Impaired vision
○ Lightheaded/ swimming	○ Provoked by loud or specific sounds
○ Trouble walking	○ Provoked by pressure changes
○ Sensation of imbalance/ tilting	○ Provoked by position changes If so, describe

6. Check any associated symptoms or other sensations which accompany your specific problem:

○ Black out or fainting when dizzy ○ Headaches ○ Double or blurry vision ○ Numbness in face or extremities ○ Weakness or clumsiness arms/ legs ○ Slurred or difficult speech	○ Tingling around mouth ○ Spots before eyes ○ Jerking of arms and legs ○ Confusion or memory loss ○ Change in hearing ○ Difficulty swallowing

7. Check any triggers that may be linked with your specific problem

○ Stress ○ Menstrual period ○ Overwork or exertion ○ Noted minutes to hours after eating ○ Straining/ lifting	○ Preceded by cold or flue ○ Recent change in eyeglasses ○ Diet ○ Noted after urinating ○ Loud noises

8. Do you have a history of motion sickness (Y/ N)? ___All my life _____Recently only

9. What medical procedures have been done previously to investigate or treat this problem (hearing tests, head scans, blood work, etc)?

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10. Do you have anything else to tell about your problem that has not already been asked by this questionnaire? ____

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11. How have you tried to treat this problem?

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12. What is your goal for being here today?

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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:

How confident are you that you will **not** lose your balance or become unsteady when you…	0	10	20	30	40	50	60	70	80	90	100
1. …walk around the house?	O	O	O	O	O	O	O	O	O	O	O
2. …walk up or down the stairs?	O	O	O	O	O	O	O	O	O	O	O
3. …bend over and pick up a slipper from the front of the closet floor?	O	O	O	O	O	O	O	O	O	O	O
4. …reach for a small can off a shelf at eye level?	O	O	O	O	O	O	O	O	O	O	O
5. …stand on your tip toes and reach for something above your head?	O	O	O	O	O	O	O	O	O	O	O
6. …stand on a chair and reach for something?	O	O	O	O	O	O	O	O	O	O	O
7. …sweep the floor?	O	O	O	O	O	O	O	O	O	O	O
8. …walk outside the house to a car parked in the driveway?	O	O	O	O	O	O	O	O	O	O	O
9. …get into and out of a car?	O	O	O	O	O	O	O	O	O	O	O
10. …walk across a parking lot to the mall?	O	O	O	O	O	O	O	O	O	O	O
11. …walk up or down a ramp?	O	O	O	O	O	O	O	O	O	O	O
12. …walk in a crowded mall where people rapidly walk past you?	O	O	O	O	O	O	O	O	O	O	O
13. …are bumped into by people as you walk through the mall?	O	O	O	O	O	O	O	O	O	O	O
14. …step onto or off of an escalator while holding onto a railing?	O	O	O	O	O	O	O	O	O	O	O
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing?	O	O	O	O	O	O	O	O	O	O	O
16. …walk outside on icy sidewalks?	O	O	O	O	O	O	O	O	O	O	O