

Name:

DOB:

Balance Rehabilitation Physical Therapy

2591 Pala Suite 110, Mission Viejo, CA 92691

Vertigo/Dizziness Questionnaire

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

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| 1. Does looking up increase your problem? (P) | Yes | Sometimes | No |
| 2. Because of your problem, do you feel frustrated? (E) | Yes | Sometimes | No |
| 3. Because of your problem, do you restrict your travel for business or recreation? (F) | Yes | Sometimes | No |
| 4. Does walking down the aisle of a supermarket increase your problem? (P) | Yes | Sometimes | No |
| 5. Because of your problem, do you have difficulty getting into or out of bed? (E) | Yes | Sometimes | No |
| 6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? (F) | Yes | Sometimes | No |
| 7. Because of your problem, do you have difficulty reading? (F) | Yes | Sometimes | No |
| 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? (P) | Yes | Sometimes | No |
| 9. Because of your problem, are you afraid to leave home without having someone with you? (E) | Yes | Sometimes | No |
| 10. Because of your problem, have you been embarrassed in front of others? (E) | Yes | Sometimes | No |
| 11. Do quick movements of your head increase your problem? (P) | Yes | Sometimes | No |
| 12. Because of your problem, do you avoid heights? (F) | Yes | Sometimes | No |
| 13. Does turning over in bed increase your problem? (P) | Yes | Sometimes | No |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yard work? (F) | Yes | Sometimes | No |
| 15. Because of your problem, are you afraid people may think you are intoxicated? (E) | Yes | Sometimes | No |
| 16. Because of your problem, is it difficult for you to go for a walk by yourself? (F) | Yes | Sometimes | No |
| 17. Does walking down a sidewalk increase your problem? (P) | Yes | Sometimes | No |
| 18. Because of your problem, is it difficult for you to concentrate? (E) | Yes | Sometimes | No |
| 19. Because of your problem, is it difficult for you to go for a walk around your house in the dark? (F) | Yes | Sometimes | No |
| 20. Because of your problem, are you afraid to stay home alone? (E) | Yes | Sometimes | No |
| 21. Because of your problem, do you feel handicapped? (E) | Yes | Sometimes | No |
| 22. Has your problem placed stress on your relationship with members of your family or friends? (E) | Yes | Sometimes | No |
| 23. Because of your problem, are you depressed? (E) | Yes | Sometimes | No |
| 24. Does your problem interfere with your job or household responsibilities? (F) | Yes | Sometimes | No |
| 25. Does bending over increase your problem? (P) | Yes | Sometimes | No |