Physical Therapy & Vestibular Rehabilitation

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Dizziness Questionnaire

Name: ____

Date: ____

	YES	NO	SOME
Does looking up increase your problem?			
Because of your problem do you feel frustrated?			
Because of your problem, do you restrict your travel for business or recreation?			
Does walking in the aisle of a supermarket increase your problem?			
Because of your problem, do you have difficulty getting into and out of bed?			
Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or parties?			
Because of your problem, do you have difficulty reading?			
Does performing more ambitious activities such as sports, dancing, household Chores (sweeping or putting dishes away) increase your problem?			
Because of your problem, are you afraid to leave your home without someone accompanying you?			
Because of your problem have you been embarrassed in front of others?			
Do quick movements of your head increase your problem?			
Because of your problem, do you avoid heights?			
Does turning over in bed increase your problem?			
Because of your problem, is it difficult for you to do strenuous housework or yard work?			
Because of your problem, do are you afraid people may think you are intoxicated?			
Because of your problem, is it difficult for you to go for a walk by yourself?			
Does walking down a sidewalk increase your problem?			
Because of your problem, is it difficult for you to concentrate?			
Because of your problem, is it difficult for you to walk in the dark?			
Because of your problem, are you afraid to stay home alone?			
Because of your problem, do you feel handicapped?			
Has the problem placed stress on your relationships with family and friends?			
Because of your problem, are you depressed?			
Does your problem interfere with your job or household responsibilities?			
Does bending over increase your problem?			
(This line to be filled out by therapist only) Total Score	X4		X2