PHOENIX NEUROLOGICAL AND SLEEP INSTITUTE

Fall Prevention Balance and Dizziness Survey

Patient Name:_____Age:_____Date:_____

To help determine if you may be headed for a fall or balance disorder, take the Balance Self-Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness, or vertigo, so that he or she may help determine the cause of your symptoms.

	Please read each question and check the box that most describes your answer.	**Yes or Often**	**Some-times**	**No or Never**
1	Do you ever lose your balance or feel dizzy or unsteady?	☐	☐	☐
2	Have you continued to experience dizziness after an injury or accident?	☐	☐	☐
3	Do you feel unsteady when you are walking or climbing stairs?	☐	☐	☐
4	Do you feel dizzy while sitting down or rising from a seated or lying position?	☐	☐	☐
5	Does walking down the aisle of a supermarket or stopping next to moving traffic make you dizzy?	☐	☐	☐
6	Does moving your head quickly make you dizzy or cause you to feel nauseous?	☐	☐	☐
7	Are you dizzy or unsteady when you first get up in the morning?	☐	☐	☐
8	Do you ever fall or feel like you are about to fall for no apparent reason?	☐	☐	☐
9	Do you use a walker, cane, or any other form of assistance for your mobility?	☐	☐	☐
10	Have you had a recent loss of, or decrease in, your vision or hearing?	☐	☐	☐
11	Do you fear falling?	☐	☐	☐
12	Have you experienced dizziness, vertigo, or serious imbalance in the past six months?	☐	☐	☐
13	Has your balance problem caused problems in your social life?	☐	☐	☐
14	Have you fallen more than once in the past year without an obvious cause?	☐	☐	☐
15	Does dizziness or imbalance interfere with your job or your household responsibilities?	☐	☐	☐

Please provide this to your physician during your visit.