R&R Physical Therapy, Inc.

Pre-Exam Balance Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Have you ever had a balance problem before? Yes No
   - 1a) If yes, did you receive any treatments at that time? Yes No
   - 1b) If yes, where?

2. Have you ever had Lightheadedness? Yes No
   Dizziness? Yes No
   Vertigo? Yes No

3. Do you have any history of falls?
   - 3a) If yes, please explain.
   - 3b) Do you have any fear of falling?
     When?
     How often?

4. Approximately when did you start to notice your balance problem? _____/_____/20_____
   - 4a) How did it start? ____

5. My balance is slowly getting: worse better staying the same

6. My balance bothers me: constantly most of the time only occasionally once in awhile

7. On a scale from 1 to 10, what is the worst your balance has been in the past several days? _____/10

   Mild difficulty *Moderate* *Unbearable, Severe*
   (circle) 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 10

8. What seems to make your balance worse?

9. What seems to make your balance better?

10. Do you have any regular numbness or tingling? Yes No If yes, where? ______________________

11. Do you have any other pain or problems? (check all that apply) Neck/Upper back Middle back Lower back Hip Elbow Shoulder/upper arm Knee Foot/ankle Other:
    - 2a) Is it deep or on the surface? Deep On the surface
    - 2b) Does it move or stay in one place?

12. List any past surgeries with dates:

13. List all medical conditions you have:

__________________________________ Patient Name

__________________________________ Signature

____/____/20____ Today's Date