

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0% 10 20 30 40 50 60 70 80 90 100%
No Confidence Completely Confident

How confident are you that you will not lose your balance or become unsteady when you...

1. ...walk around the house? _____%
2. ...walk up or down stairs? _____%
3. ...bend over and pick up a slipper from the front of a closet floor? _____%
4. ...reach for a small can off a shelf at eye level? _____%
5. ...stand on your tip toes and reach for something above your head? _____%
6. ...stand on a chair and reach for something? _____%
7. ...sweep the floor? _____%
8. ...walk outside the house to a car parked in the driveway? _____%
9. ...get into or out of a car? _____%
10. ...walk across a parking lot to the mall? _____%
11. ...walk up or down a ramp? _____%
12. ...walk in a crowded mall where people rapidly walk past you? _____%
13. ...are bumped into by people as you walk through the mall? _____%
14. ...step onto or off of an escalator while you are holding onto a railing? _____%
15. ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. ...walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____ % of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY

100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ Date: _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling “yes or “no” or “sometimes” for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes ¹	No ²	Sometimes ³
E2.	Because of your problem, do you feel frustrated?	Yes ¹	No ²	Sometimes ³
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes ¹	No ²	Sometimes ³
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes ¹	No ²	Sometimes ³
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes ¹	No ²	Sometimes ³
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes ¹	No ²	Sometimes ³
F7.	Because of your problem, do you have difficulty reading?	Yes ¹	No ²	Sometimes ³
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes ¹	No ²	Sometimes ³
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes ¹	No ²	Sometimes ³
E10.	Because of your problem, have you been embarrassed in front of others?	Yes ¹	No ²	Sometimes ³
P11.	Do quick movements of your head increase your problem?	Yes ¹	No ²	Sometimes ³
F12.	Because of your problem, do you avoid heights?	Yes ¹	No ²	Sometimes ³
P13.	Does turning over in bed increase your problem?	Yes ¹	No ²	Sometimes ³
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes ¹	No ²	Sometimes ³
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes ¹	No ²	Sometimes ³
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes ¹	No ²	Sometimes ³
P17.	Does walking down a sidewalk increase your problem?	Yes ¹	No ²	Sometimes ³
E18.	Because of your problem, is it difficult for you to concentrate?	Yes ¹	No ²	Sometimes ³
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes ¹	No ²	Sometimes ³
E20.	Because of your problem, are you afraid to stay home alone?	Yes ¹	No ²	Sometimes ³
E21.	Because of your problem, do you feel handicapped?	Yes ¹	No ²	Sometimes ³

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes ¹	No ²	Sometimes ³
E23.	Because of your problem, are you depressed?	Yes ¹	No ²	Sometimes ³
F24.	Does your problem interfere with your job or household responsibilities?	Yes ¹	No ²	Sometimes ³
P25.	Does bending over increase your problem?	Yes ¹	No ²	Sometimes ³

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- Negligible symptoms (0)
- Bothersome symptoms (1)
- Performs usual work duties but symptoms interfere with outside activities (2)
- Symptoms disrupt performance of both usual work duties and outside activities (3)
- Currently on medical leave or had to change jobs because of symptoms (4)
- Unable to work for over one year or established permanent disability with compensation payments (5)

Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____