BALANCE CHICAGO

Activities-Specific Balance Confidence Scale (ABC)

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

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Confidence **Moderate Confidence** **Completely Confident**

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

1. Walking around the house? _____ %
2. Walking up or down the stairs? _____ %
3. Bending over to pick up a slipper or item from the front of the closet floor? _____ %
4. Reaching for a small can off of a shelf at eye level? _____ %
5. Standing on your tiptoes and reaching for something above your head? _____ %
6. Sweeping the floor? _____ %
7. Walking outside of the house to a car parked in the driveway? _____ %
8. Standing on a chair and reaching for something? _____ %
9. Getting in or out of a car? _____ %
10. Walking across the parking lot to the mall? _____ %
11. Walking up or down a ramp? _____ %
12. Walking in a crowded mall where people rapidly walk past you? _____ %
13. Are bumped into by people as you walk through the mall? _____ %
14. Step on or off an escalator while you are holding onto a rail? _____ %
15. Step onto/off an escalator while holding items and you cannot hold onto the railing? _____ %
16. Walking outside on a wet or slippery sidewalk? _____ %

Patient Name: _____ Date: _____

To be completed by office staff:

Score: _____

BALANCE CHICAGO

Dizziness Handicap Index (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes," "no," or "sometimes" to each question by writing the corresponding letter in the blanks on the right side of the paper. *Answer each question as it pertains to your dizziness or unsteadiness only.*

Y = yes **N = no** **S = sometimes**

	Your Answer	Office Use
1. Does looking up increase your problem?	_____	P _____
2. Because of your problem do you feel frustrated?	_____	E _____
3. Because of your problem do you restrict your travel for business/recreation?	_____	F _____
4. Does walking down the aisle of a supermarket increase your problem?	_____	P _____
5. Because of your problem do you have difficulty getting into or out of bed?	_____	F _____
6. Does your problem significantly restrict your participation in social activities such as going to dinner, movies, dancing, or parties?	_____	F _____
7. Because of your problem do you have difficulty reading?	_____	F _____
8. Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting away dishes increase your problem?	_____	P _____
9. Because of your problems are you afraid to leave your home without having someone accompany you?	_____	E _____
10. Because of your problem are you embarrassed in front of others?	_____	E _____
11. Do quick movements of your head increase your problem?	_____	P _____
12. Because of your problem do you avoid heights?	_____	F _____
13. Does turning over in bed increase your problem?	_____	P _____
14. Because of your problem is it difficult for you to do strenuous homework or yard work?	_____	F _____
15. Because of your problem are you afraid people think you are intoxicated?	_____	E _____
16. Because of your problem is it difficult for you to walk by yourself?	_____	F _____
17. Does walking down a sidewalk increase your problem?	_____	P _____
18. Because of your problem is it difficult for you to concentrate?	_____	E _____
19. Because of your problem is it difficult for you to walk around your house in the dark?	_____	F _____
20. Because of your problem are you afraid to stay home?	_____	E _____
21. Because of your problem do you feel handicapped?	_____	E _____
22. Has your problem placed stress on your relationships with members of your family?	_____	E _____
23. Because of your problem are you depressed?	_____	E _____
24. Does your problem interfere with your job or household responsibilities?	_____	F _____
25. Does bending over increase your problem?	_____	P _____

Patient Name: _____ Date: _____

To be completed by office staff:

Scores: F _____ (36) E _____ (36) P _____ (28) Total Score: _____ (100)