

Patient Name _____

Date: _____

DOB: _____

Office ID #: _____

Initial:

Follow-up:

Clinician: _____

Instructions for patients:

Please answer each question based on your experience **TODAY**. Select the option that best describes you by circling the number next to the option..

Section 1

1. How often do you feel unsteady when standing or walking?

- 0 = Never (no unsteadiness)
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

2. How often do you lose your balance or stumble?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

3. How much does imbalance interfere with daily activities (e.g., walking, dressing, cooking)?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)

3 = Often (3–5 times per week)

4 = Always (daily or constant)

4. How confident are you in maintaining balance during activities (e.g., climbing stairs, reaching overhead)?

- 0 = Very confident
- 1 = Mostly confident
- 2 = Somewhat confident
- 3 = Rarely confident
- 4 = Not confident at all

5. Do you avoid activities (stairs, shopping) because of balance concerns?

- 0 = Never (no avoidance)
- 1 = Rarely (avoidance less than once a week)
- 2 = Sometimes (avoidance 1–2 times per week)
- 3 = Often (avoidance 3–5 times per week)
- 4 = Always (avoidance daily or constant)

Total Score: _____

Section 2

1. Do you feel lightheaded or faint when standing up?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)
2. Do you experience rapid heartbeat, palpitations or near-fainting?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)
3. Do you have abnormal sweating (too much or too little)?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)
4. Do you have digestive or bladder symptoms (constipation, early fullness, diarrhea, urgency, or incontinence)?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)

5. Do autonomic symptoms interfere with daily activities?

- 0 = Not at all
1 = Mildly (noticeable but no limitation)
2 = Moderately (some limitation)
3 = Severely (major limitation)
4 = Completely disabling

Total Score: _____

Section 3

1. How often do you experience involuntary muscle contractions, tremors, or abnormal posturing?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)
2. How often do tremors or shaking interfere with daily tasks?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)
3. How often do stiffness or rigidity limit your movements?
0 = Never
1 = Rarely (less than once a week)
2 = Sometimes (1–2 times per week)
3 = Often (3–5 times per week)
4 = Always (daily or constant)

4. Do symptoms worsen with stress or fatigue?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
5. How often do you have difficulty initiating movements (slowness, hesitation)?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
- Total Score:** _____

Section 4

1. How often do you have difficulty remembering recent events or appointments?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
2. Do you have trouble concentrating on reading or tasks?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

3. Do you lose track of what you are doing?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
4. Do you have difficulty finding words?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
5. How often do your thinking problems interfere with daily life?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
- Total Score:** _____

Section 5

1. How often do you experience headaches since your injury?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

2. How often do you feel dizzy or off balance?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
3. How often do you feel slowed down or mentally foggy?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
4. How often do you feel more fatigued than usual?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
5. How often do you have sensitivity to light or noise?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

Total Score: _____

Section 6

1. How often do you experience headaches?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
2. How severe is your typical headache pain?
 - 0 = None (no pain)
 - 1 = Mild (noticeable but does not interfere with activities)
 - 2 = Moderate (interferes somewhat with activities)
 - 3 = Severe (significantly interferes with activities)
 - 4 = Worst possible (completely disabling pain)
3. How often have you needed medication for headache relief?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
4. How often do you avoid activities because of headaches?
 - 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

5. How often do headaches interfere with sleep?

- 0 = Never (no interference)
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant interference)

Total Score: _____

Section 7

1. Do you feel dizzy when turning your head quickly?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

2. Do you feel dizzy when standing up?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

3. Do you avoid certain movements due to dizziness?

- 0 = Never (no avoidance)
- 1 = Rarely (avoidance less than once a week)
- 2 = Sometimes (avoidance 1–2 times per week)

3 = Often (avoidance 3–5 times per week)

4 = Always (avoidance daily or constant)

4. How often do you feel unsteady when walking in the dark or on uneven ground?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

5. Do you feel anxious about dizziness in public?

- 0 = Never
- 1 = Rarely (less than once a week)
- 2 = Sometimes (1–2 times per week)
- 3 = Often (3–5 times per week)
- 4 = Always (daily or constant)

Total Score: _____

Section 8

1. Do busy visual environments (e.g., supermarkets, scrolling screens) make you feel dizzy or uncomfortable?

- 0 = Never (no symptoms)
- 1 = Rarely (mild, infrequent)
- 2 = Sometimes (moderate, occasional)
- 3 = Often (severe, frequent)
- 4 = Always (constant, disabling)

2. Do moving patterns (e.g., crowds, traffic, escalators) trigger nausea, headache, or imbalance?

0 = Never

1 = Rarely (mild, infrequent)

2 = Sometimes (moderate, occasional)

3 = Often (severe, frequent)

4 = Always (symptoms consistently triggered, disabling)

3. Do you feel worse with screen use (video games, VR, rapid scrolling)?

0 = Never

1 = Rarely (mild discomfort after prolonged use)

2 = Sometimes (moderate discomfort, requires breaks)

3 = Often (severe discomfort, limits screen use)

4 = Always (unable to tolerate screen use)

4. Do you avoid places with lots of visual motion (e.g., malls, stations) to prevent symptoms?

0 = Never (no avoidance)

1 = Rarely (avoidance once in a while)

2 = Sometimes (avoidance of some environments)

3 = Often (frequent avoidance, limits activities)

4 = Always (consistently avoid such environments)

5. When symptoms occur, how severe are they on average?

0 = None (no symptoms)

1 = Mild (noticeable but does not interfere with activities)

2 = Moderate (interferes somewhat with activities)

3 = Severe (significantly interferes with activities)

4 = Worst possible (completely disabling when triggered)

Total Score: _____

Section 9

1. How intense has your neck pain been this week?

0 = None

1 = Mild (noticeable but does not interfere with activities)

2 = Moderate (interferes somewhat with activities)

3 = Severe (significantly interferes with activities)

4 = Worst possible (constant, disabling pain)

2. Has your neck pain interfered with sleep?

0 = Not at all

1 = Mildly (occasional disturbance)

2 = Moderately (frequent disturbance)

3 = Severely (most nights disturbed)

4 = Completely (unable to sleep due to pain)

3. Has your neck pain limited your ability to turn your head (e.g., driving)?

0 = Not at all

1 = Mildly (slight stiffness, no major limitation)

2 = Moderately (noticeable limitation, some difficulty)

3 = Severely (major limitation, frequent difficulty)

4 = Unable (cannot turn head adequately)

4. Has your neck pain interfered with work, household, or recreational activities?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Completely (unable to perform activities)

5. Do you avoid activities because of your neck pain?

0 = Never

1 = Rarely (less than once a week)

2 = Sometimes (1–2 times per week)

3 = Often (3–5 times per week)

4 = Always (daily or constant)

Total Score: _____

Section 10

1. How intense has your low back pain been this week?

0 = None (no pain)

1 = Mild (noticeable but does not interfere with activities)

2 = Moderate (interferes somewhat with activities)

3 = Severe (significantly interferes with activities)

4 = Worst possible (constant, disabling pain)

2. Has back pain limited your ability to sit, stand, or walk?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Unable (cannot sit, stand, or walk independently)

3. Has back pain interfered with lifting or carrying objects?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Unable (cannot lift or carry at all)

4. Has back pain interfered with sleep?

0 = Not at all

1 = Mildly (occasional disturbance)

2 = Moderately (frequent disturbance)

3 = Severely (most nights disturbed)

4 = Completely (unable to sleep due to pain)

5. Do you avoid activities (work, exercise, recreation) because of back pain?
- 0 = Never
 - 1 = Rarely (avoidance less than once a week)
 - 2 = Sometimes (avoidance 1–2 times per week)
 - 3 = Often (avoidance 3–5 times per week)
 - 4 = Always (avoidance daily or constant)

Total Score: _____

Section 11

1. How often have you felt unusually tired during the day?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
2. How often have you struggled to stay awake during activities?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
3. How often has poor sleep interfered with your daily functioning?
- 0 = Not at all

- 1 = Mildly (noticeable but no limitation)
- 2 = Moderately (some limitation)
- 3 = Severely (major limitation)
- 4 = Completely (unable to function due to poor sleep)

4. How often do you wake feeling unrefreshed?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)
5. How often do you avoid activities due to fatigue?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

Total Score: _____

Section 12

1. How often have you felt down, depressed, or hopeless?
- 0 = Never
 - 1 = Rarely (less than once a week)
 - 2 = Sometimes (1–2 times per week)
 - 3 = Often (3–5 times per week)
 - 4 = Always (daily or constant)

2. How often have you felt nervous, anxious, or on edge?

0 = Never

1 = Rarely (less than once a week)

2 = Sometimes (1–2 times per week)

3 = Often (3–5 times per week)

4 = Always (daily or constant)

3. How often have you lost interest or pleasure in activities?

0 = Never

1 = Rarely (less than once a week)

2 = Sometimes (1–2 times per week)

3 = Often (3–5 times per week)

4 = Always (daily or constant)

4. How often have you felt overwhelmed by your symptoms?

0 = Never

1 = Rarely (less than once a week)

2 = Sometimes (1–2 times per week)

3 = Often (3–5 times per week)

4 = Always (daily or constant)

5. How often have mood symptoms interfered with daily life?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Completely (unable to function due to mood symptoms)

Total Score: _____

Section 13

1. How would you rate your overall quality of life this week?

0 = Excellent

1 = Good

2 = Fair

3 = Poor

4 = Very poor

2. How much have your symptoms interfered with social activities?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Completely (unable to participate)

3. How much have your symptoms interfered with family activities?

0 = Not at all

1 = Mildly (noticeable but no limitation)

2 = Moderately (some limitation)

3 = Severely (major limitation)

4 = Completely (unable to participate)

4. How much have your symptoms interfered with work or school?
- 0 = Not at all
 - 1 = Mildly (noticeable but no limitation)
 - 2 = Moderately (some limitation)
 - 3 = Severely (major limitation)
 - 4 = Completely (unable to participate)

5. How satisfied are you with your ability to carry out daily roles?
- 0 = Very satisfied
 - 1 = Satisfied
 - 2 = Neutral
 - 3 = Dissatisfied
 - 4 = Very dissatisfied

Total Score: _____

Section 14

1. How much has pain interfered with your enjoyment of life?
- 0 = Not at all
 - 1 = A little bit (noticeable but minimal effect)
 - 2 = Moderately (somewhat limits enjoyment)
 - 3 = Quite a bit (significantly limits enjoyment)
 - 4 = Extremely (completely prevents enjoyment)

2. How much has the pain interfered with your ability to concentrate?
- 0 = Not at all
 - 1 = A little bit (mild distraction)
 - 2 = Moderately (frequent distraction, some tasks affected)
 - 3 = Quite a bit (major distraction, many tasks affected)
 - 4 = Extremely (unable to concentrate at all)

3. How much has the pain interfered with your ability to move around?
- 0 = Not at all
 - 1 = A little bit (slight limitation)
 - 2 = Moderately (some activities limited)
 - 3 = Quite a bit (most activities limited)
 - 4 = Extremely (unable to move around independently)

4. How much has the pain interfered with your mood?
- 0 = Not at all
 - 1 = A little bit (occasional irritability or sadness)
 - 2 = Moderately (frequent mood changes)
 - 3 = Quite a bit (persistent mood disturbance)
 - 4 = Extremely (constant, disabling mood disturbance)

5. How much has the pain interfered with your sleep?

0 = Not at all

1 = A little bit (occasional disturbance)

2 = Moderately (frequent disturbance)

3 = Quite a bit (most night disturbed)

4 = Extremely (unable to sleep due to pain)

Total Score: _____