**Patient Name** _____ **Date:** _____

**DOB:** _____ **Office ID #:** _____

**Initial:** □

**Follow-up:** □ **Clinician:** _____

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**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..

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## 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: _____**

**For Internal Use Only**

**Patient Information** **Date:** _____

- **Name:** _____
- **DOB:** _____
- **Clinician:** _____

**Domain Scores**

| Section | Score (0–20) | Patient Color Band | Notes |
|---|---|---|---|
| 1. Ataxia / Balance | |  | |
| 2. Dysautonomia | |  | |
| 3. Dystonia / Movement Disorder | |  | |
| 4. Cognitive | |  | |
| 5. Concussion | |  | |
| 6. Headaches | |  | |
| 7. Vestibular / Dizziness | |  | |
| 8. Visual Motion Sensitivity | |  | |
| 9. Neck Pain | |  | |
| 10. Low Back Pain | |  | |
| 11. Fatigue / Sleep | |  | |
| 12. Mood / Emotional Health | |  | |
| 13. Quality of Life / Participation | |  | |
| 14. General Pain Interference | |  | |
| **Total Score** | **/280** |  | |

**Color Band Key (Per Section: 0–20)**

- 0–5 = Doing well (minimal issues)
- 6–10 = Mild issues (symptoms noticeable but manageable)
- 11–15 = Moderate issues (symptoms often interfere with life)
- 16–20 = Severe issues (symptoms strongly limit daily life)

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**Global Score Interpretation (0–280)**

- 0–60 = Minimal overall impact
- 61–120 = Mild overall impact
- 121–180 = Moderate overall impact
- 181–280 = Severe overall impact

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**Initial Areas of Patient Concern**

1. _____
2. _____
3. _____

**Progress Tracking Chart**

| Date | Total Score | Severity | Notes |
|---|---|---|---|
| ___/___/___ | /280 | | |
| ___/___/___ | /280 | | |
| ___/___/___ | /280 | | |
| ___/___/___ | /280 | | |

**Clinician:** _____