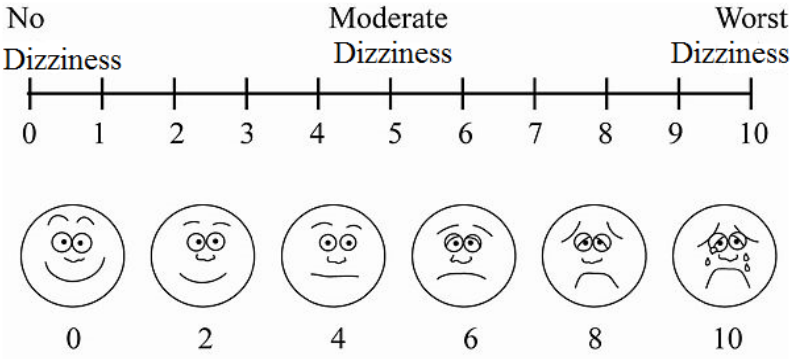
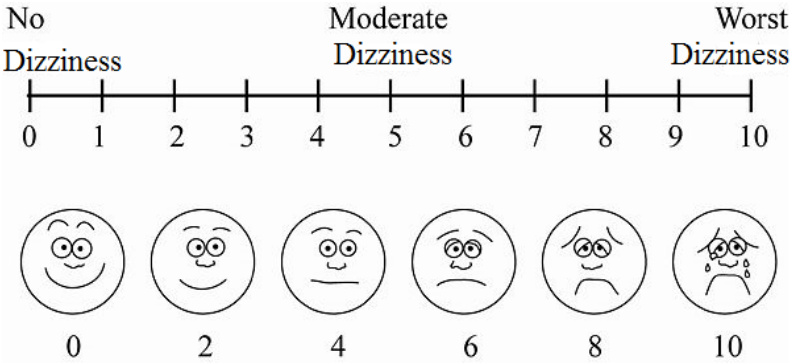
Patient Name: _____ Date: _____

Dizziness/Unsteadiness Symptoms Scale: Follow-up

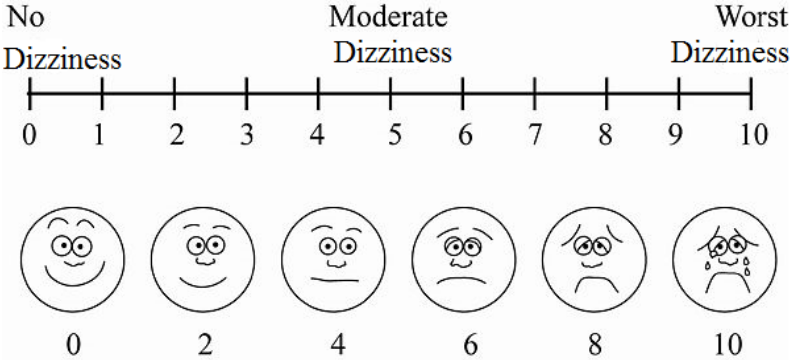
Instructions: Please rate your symptoms *after the therapy program* at its worst, at its best and today.



Symptoms at its worst



Symptoms today



Symptoms at its best