

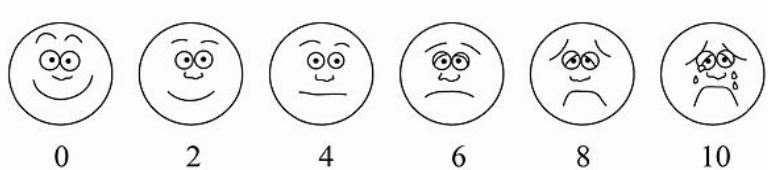
Patient Name: _____ Date: _____

Dizziness/Unsteadiness Symptoms Scale: Follow-up

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

No Dizziness Moderate Dizziness Worst Dizziness

0 1 2 3 4 5 6 7 8 9 10

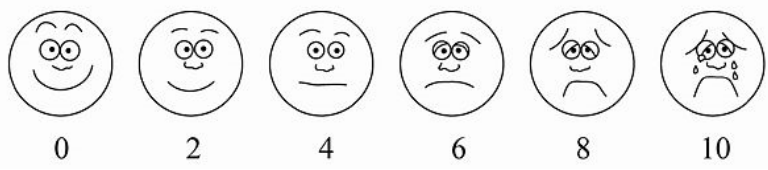


0 2 4 6 8 10

Symptoms at its worst

No Dizziness Moderate Dizziness Worst Dizziness

0 1 2 3 4 5 6 7 8 9 10

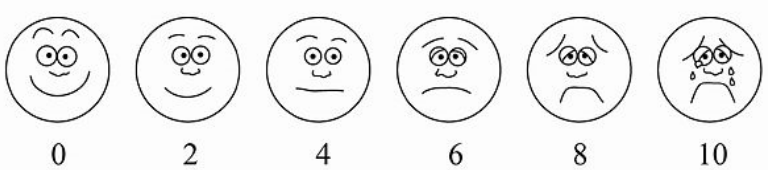


0 2 4 6 8 10

Symptoms today

No Dizziness Moderate Dizziness Worst Dizziness

0 1 2 3 4 5 6 7 8 9 10



0 2 4 6 8 10

Symptoms at its best