

Michigan Advanced Pain & Spine

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Balance Self-Test

Patient Name: _____ Date of Birth: _____

1. Have you fallen in the past year? Yes No

2. Do you feel dizzy or off balance if you make a sudden change in movement, such as bending down or quickly turning? Yes No

3. Do you have any hearing loss? Yes No

4. Do you require assistance to walk, such as a person supporting you, use a walker or a wheelchair? Yes No

5. Do you have balance problems when you are walking or climbing stairs? Yes No

Patient Signature: _____ Date: _____