Patient Name:

DOB:

MR#

Date:_____

**University of Wisconsin Hospital and Clinics**
600 Highland Avenue | Madison, Wisconsin 53792

**REHABILITATION CLINIC -**
**ACTIVITIES - SPECIFIC BALANCE CONFIDENCE (ABC) SCALE**

**Instructions to Participants**

For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. **If you do not currently do the activity in question, try and imagine how confident you would be if you had to the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.** If you have any questions about answering any of these items, please ask the Therapist.

For each of the following activities, please indicate your level of self confidence by choosing a corresponding number from the following rating scale:

**0% 10 20 30 40 50 60 70 80 90 100%**
**no confidence** **completely confident**

"How confident are you that you will not lose your balance or become unsteady when you..."

1. ...walk around the house? ____%
2. ...walk up or down stairs? ____%
3. ...bend over a pick a slipper from the front of a closet floor? ____%
4. ...reach for a small can off a shelf at eye level? ____%
5. ...stand on your tip toes and reach for something above your head? ____%
6. ...stand on a chair and reach for something? ____%
7. ...sweep the floor? ____%
8. ...walk outside the house to a car parked in the driveway? ____%
9. ...get into or out of a car? ____%
10. ...walk across a parking lot to the mall? ____%
11. ...walk up or down a ramp? ____%
12. ...walk in a crowded mall where people rapidly walk past you? ____%
13. ...are bumped into by people as you walk throught the mall? ____%
14. ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
15. ...step onto or off an escalator while holding onto the railing? ____%
16. ...walk outside on icy sidewalks? ____%

**For Therapist Use Only** **Total =** _____ **Average (Total ÷ 16) =** _____

**If you have dizziness, please fill out the Dizziness Handicap Inventory (DHI) Form**

Completed by:_____ Date:_____
If not the patient, please list relationship:_____

Reviewed by:_____ Date:_____ Time:_____ Pager:_____