

Vestibular Rehabilitation Patient Intake Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Questions about what brings you to our office:

1. Please describe the first event:

Date: _____

What you were doing: _____

Symptoms experienced: _____

How long symptoms lasted: _____

2. Did you have a viral infection (lung or gastrointestinal) 1-2 weeks before your symptoms began? YES / NO

3. What symptoms are you experiencing with this complaint? (please check)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> falls or near falls | <input type="checkbox"/> motion sickness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Vomiting | <input type="checkbox"/> headaches | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> fullness in the ear | <input type="checkbox"/> dizziness | <input type="checkbox"/> neck pain | |
| <input type="checkbox"/> Decreased vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Blurry vision | |
| <input type="checkbox"/> facial muscle weakness | | <input type="checkbox"/> spinning (self or room) | |
| <input type="checkbox"/> staggering / imbalance | | <input type="checkbox"/> floating inside the head | |
| <input type="checkbox"/> quick head movements | | | |

4. To what extent is your dizziness or imbalance brought on by:

	NONE	SOME	SEVERELY
Turning over in bed, bending, or looking up			
Standing up			
Getting up out of bed			
Rapid head movements			
Walking in a dark room			
Walking on uneven surfaces			
Loud noises			
Cough, sneeze, strain, laugh			
Movement of objects around you (cars,...)			
Moving your eyes with your head still			
Wide open spaces			
Tunnels, bridges, supermarkets			
Menstrual periods			
Changes in lighting			
Shortly after eating			
With any increase in activity			

Patient's Name _____

D.O.B. _____

DATE _____

5. Other questions concerning dizziness (please circle):

Can you bring on your dizziness voluntarily? NO / YES

If yes, how? _____

Do you avoid certain situations or movements? NO / YES

If yes, what? _____

Is your dizziness CONSTANT or INTERMITTENT?

6. What tests have you had for this complaint?

MRI CT scan Xray audiogram (hearing test)

calorics, ENG, and/or posturography (by an ENT)

Questions about your general health:

7. Please check all the medical conditions that you have or have had:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> stomach disorder | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> cancer | <input type="checkbox"/> anxiety | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> lung problems | <input type="checkbox"/> depression | <input type="checkbox"/> ear infections |
| <input type="checkbox"/> migraine | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> barotrauma (diving) |
| <input type="checkbox"/> neck problems | <input type="checkbox"/> concussion / head trauma | | <input type="checkbox"/> crossed or lazy eye |
| <input type="checkbox"/> ear prosthesis | <input type="checkbox"/> other: _____ | | |

8. Please check all of the following items that apply to you:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> hearing problems | <input type="checkbox"/> pregnant | <input type="checkbox"/> visual problems |
| <input type="checkbox"/> smoke | <input type="checkbox"/> car accident | <input type="checkbox"/> recent air/sea travel |
| <input type="checkbox"/> recent dental procedure | | <input type="checkbox"/> history of chemical / alcohol dependence |
| <input type="checkbox"/> recent hair appointment or massage | | <input type="checkbox"/> bowel or bladder control issues |
| <input type="checkbox"/> use of antibiotics (recent or in past) | | <input type="checkbox"/> learning problems |
| <input type="checkbox"/> exposure to heavy metals | | <input type="checkbox"/> exposure to toxins in utero (before born) |
| <input type="checkbox"/> more than 2 daily servings of caffeine (coffee, soda,...), or alcohol | | |
| <input type="checkbox"/> family history of headaches, Meniere's, hearing loss, vertigo, neurological disease | | |

9. Please list surgeries: _____

10. Please list allergies: _____

11. Please list ALL medications you are currently taking:

