Vitality Physical Therapy & Wellness

VESTIBULAR QUESTIONNAIRE

Name: ___________________________ **Age**: __________ **Height**:__________ **Weight**: __________ **Today's Date:** _______________

When did it start? __________**Have you had this problem before?** ________ **If Yes, When?:** ____________________________________

<u>Past Medical History</u> (circle those that apply now or in the past):

hearing loss	severe headaches	epilepsy	IV antibiotic treatment
Meniere's disease	panic attacks	stroke	high blood pressure
cardiac problems	carsickness	joint replacement	osteoarthritis
pacemaker	spine surgery/injury	visual loss	rheumatoid arthritis
diabetes	multiple sclerosis	serious head trauma	osteoporosis
surgery	asthma	Parkinson's disease	cancer
ear surgery			

Other: ____

Family History (circle those that apply):

severe headaches	dizziness vertigo	carsickness	Meniere's
imbalance	deafness	panic attack	depression

Which best describes your dizziness? (circle those that apply):

spinning/rotation	floating	rocking motion	tilting
head fullness	free falling	poor balance	motion sickness
feel that you may fall	nausea		

Other: ____

Is your dizziness: intermittent continuous continuous, but periodically worsens

When you have dizziness, how long does it last? (circle those that apply):

continuous	seconds (<1 minute)	minutes
hours	days	weeks, months, years

Rate intensity of dizziness on a scale 0-10:

Baseline Now __________ Average day recently __________ Peak attack __________

If you have attacks of dizziness or periods of worsening, when do they occur ?(circle those that apply):

turning in bed, rolling over, looking up	with menstruation
seeing things in motion	hunger
no particular pattern	stress
with head movement	weather changes
turning eyes side to side	in crowded places
with fatigue	Other: ____

Have you ever had several minutes of:

double vision	slurred speech	weakness/numbness on one side
blindness	flashes of light/zigzag lines	inability to speak

Reviewed MB 6/2015

If you have imbalance, which describes the problem?

loss of equilibrium　　environment seems unstable or in motion

off balance only when standing　　off balance standing, sitting or lying down

Do you have hearing loss? Yes No **If yes, on:** right left both in attacks?

Do you have ringing in your ears? Yes No **If yes, on:** right left both in attacks?

Do you have hearing aids? Yes No

Have you had a hearing test before: Yes No **When?** ___________________

Are you on disability? Yes No **If yes, how long?** ____

My illness/injury/surgery interferes with my normal activities (work, leisure, activities of daily living):

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Are you unable to:

work　drive a car　grocery shop　go in a mall or theater

ride elevators　ride in a car　walk　walk on unstable surfaces

Home Environment: (check all that apply)

☐ Live alone
☐ Live with someone who can/does assist me
☐ Single parent
☐ Ill/disabled family member
☐ Live with children
☐ Other

Do you use an assistive device for ambulation? Yes No

What:_________________________________

How many stairs in your home _____________________________

Railing? _______ Which side when stepping down? ___________

Type of shower:

☐ Tub ☐ Combination tub/shower
☐ Walk in shower

My home is:

☐ Single level ☐ Mobile home ☐ RV
☐ 2 story ☐ Park model

Are you a licensed driver?

☐ Yes ☐ No

Please list 3 things that are difficult to do because of your current condition and 3 goals you would like to work on.

Difficult things to do:

1. ____
2. ____
3. ____

Goals:

1. ____
2. ____
3. ____

Patient Signature: ____ **Date:**_______________

** **RETURNING PATIENTS ONLY: I HAVE REVIEWED AND UPDATED THE ABOVE INFORMATION** **

Patient Signature: ____ **Date:**_______________

Provider Notes:

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