Vestibular Intake Form

Name: ___________________________ Date: __________________

Occupation: ___________________________ Full-time □ Part-time □ Other □

Primary Concern:
History of falls? No □ Yes □ If yes how often? ___________ When was last fall? ___________
Describe the problem that brings you to therapy: ___________________________

Date problem began: ___________ Since then, has your problem: Worsened □ Improved □ Same □
Have you experienced a recent trauma? No □ Yes □ If yes describe: ___________
Have you ever experienced this problem before? No □ Yes □ If yes, please describe: ___________

Symptoms:
Symptom Description (circle all that apply):

<table>
<thead>
<tr>
<th>Light Headedness</th>
<th>Visual Disturbances</th>
<th>Disorientation</th>
<th>Hearing loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Rocking/ Swaying</td>
<td>Difficulty with Memory</td>
<td>Ringing in ears</td>
</tr>
<tr>
<td>Nausea</td>
<td>Spinning</td>
<td>Facial Numbness</td>
<td>Ear fullness/ pressure</td>
</tr>
<tr>
<td>Passing out/ Fainting</td>
<td>Balance Difficulty</td>
<td>Fatigue/ weakness</td>
<td>Other: __________</td>
</tr>
</tbody>
</table>

How often do symptoms occur? Daily □ Weekly □ Constantly □
How long do symptoms last? Seconds □ Minutes □ Hours □ Days □

Symptoms increase with (circle all that apply):

<table>
<thead>
<tr>
<th>Rolling in bed</th>
<th>Turn head</th>
<th>Walking</th>
<th>Bearing down/ Straining</th>
<th>Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying to sit</td>
<td>Look up/Down</td>
<td>Crowds</td>
<td>Lying down</td>
<td>Loud Noises</td>
</tr>
<tr>
<td>Sit to stand</td>
<td>Bending/ Squatting</td>
<td>Driving</td>
<td>Cough/ Sneeze</td>
<td>Other</td>
</tr>
</tbody>
</table>

Medical History:
Circle all that Apply:

<table>
<thead>
<tr>
<th>Osteoporosis</th>
<th>Previous Therapy</th>
<th>Seizure/ Epilepsy</th>
<th>Anemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>Arthritis</td>
<td>Numbness/ Tingling</td>
<td>Asthma</td>
</tr>
<tr>
<td>Diabetes 1</td>
<td>Anxiety</td>
<td>Head Injury/ Concussion</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Diabetes 2</td>
<td>Depression</td>
<td>Thyroid Problems</td>
<td>Other</td>
</tr>
</tbody>
</table>

Describe any items that are circled: __________________________________________
Surgical history (type/date): ________________________________________________

Current Medications:
Prescriptions □ Vitamins □ Over the Counter □ Herbals □

Imaging: (X-Ray, MRI, EMG, CT scan etc):

List of Medications: ___________________________

_________________________________________                            _____________________

Patient/Guardian Signature                      Date
In the last WEEK what percentage of the time has dizziness interfered with your activities? Mark on line below.

[-----------------------------]
0% 25% 50% 75% 100%

Dizziness Handicap Inventory

Part 1 Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadness. Please indicate answer by circling “yes” or “no” or “sometimes” for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem? Yes No Sometimes
E2. Because of your problem, do you feel frustrated? Yes No Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation? Yes No Sometimes
P4. Does walking down the aisle of a supermarket increase your problem? Yes No Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed? Yes No Sometimes
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties? Yes No Sometimes
F7. Because of your problem, do you have difficulty reading? Yes No Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem? Yes No Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you? Yes No Sometimes
E10. Because of your problem, have you been embarrassed in front of others? Yes No Sometimes
P11. Do quick movements of your head increase your problem? Yes No Sometimes
F12. Because of your problem, do you avoid heights? Yes No Sometimes
P13. Does turning over in bed increase your problem? Yes No Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work? Yes No Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated? Yes No Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself? Yes No Sometimes
P17. Does walking down a sidewalk increase your problem? Yes No Sometimes
E18. Because of your problem, is it difficult for you to concentrate? Yes No Sometimes
F19. Because of your problem, is it difficult for you walk around the house in the dark? Yes No Sometimes
E20. Because of your problem, are you afraid to stay home alone? Yes No Sometimes
E21. Because of your problem, do you feel handicapped? Yes No Sometimes
E22. Has your problem placed stress on your relationships with members of your family or friends? Yes No Sometimes
E23. Because of your problem, are you depressed? Yes No Sometimes
F24. Does your problem interfere with your job or household responsibilities? Yes No Sometimes
P25. Does bending over increase your problem? Yes No Sometimes

Part 2 Instructions: Put a check in the box that best describes you.

- Negligible symptoms (0)
- Bothersome symptoms (1)
- Performs usual work duties but symptoms interfere with outside activities (2)
- Symptoms disrupt performance of both usual work duties and outside activities (3)
- Currently on medical leave or had to change jobs because of symptoms (4)
- Unable to work for over one year or established permanent disability with compensation payments (5)