Vestibular Patient Intake Form

NAME: ____ DOB: __________ Date: __________

Approximately when did your symptoms begin and how long have they been occurring?

____

____

____

WITHOUT using the words "dizzy" or "vertigo" describe what your symptoms feel like in detail:

____

____

____

____

____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE ANSWER (**Y**=YES and **N**=NO) THAT MOST PERTAINS TO YOU. IF A LINE IS PROVIDED, PLEASE ANSWER APPROPRIATELY.

How often does your dizziness/vertigo occur? **(Check all that apply)**

DAILY WEEKLY MONTHLY YEARLY

How long does the dizziness/vertigo last when it occurs? **(Check all that apply)**

SECONDS MINUTES HOURS DAYS CONSTANT

Does your dizziness/vertigo fluctuate in intensity? Y/N

Does your dizziness/vertigo fluctuate in frequency? Y/N

Do your symptoms occur when lying down, getting up, rolling over, looking up or bending over? Y/N

Did your dizziness ***BEGIN DIRECTLY AFTER*** being on a boat/cruise ship for an extended period? Y/N

Is your dizziness ***BETTER WHEN MOVING*** but ***WORSE WHEN COMPLETELY STILL***? Y/N

Do you currently have or have ever had a history of headaches or migraines? Y/N

- How often do your headaches occur? ________________
- How long do your headaches last when they occur? ___________________

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Do you feel as though your head is in a fog? Y/N

Do you have a sensitivity to bright lights? Y/N

Do you have a sensitivity to loud sounds? Y/N

Do you have any numbness or tingling in your face at any time? Y/N

Do you experience visual auras? (ie. Tunnel Vision, Colored Spots, etc.) Y/N

Do you experience motion sickness or a sensitivity to motion? (ie. Riding in the car) Y/N

Do you currently or have ever had a history of cancer? Y/N

- How was this condition treated? **(Check all that apply)**
  Surgery Medications Radiation Chemotherapy
- If treatment is complete, how long have you been in remission? _______________

Do you have a history of high blood pressure? Y/N

- How long has this condition been present? _______________
- What is being done to manage it?
  ____

Do you currently have or have ever had a history of diabetes? Y/N

- How long has this condition been present? _______________
- What is being done to manage it?
  ____

Do you have any autoimmune disorders? Y/N

- How long has this condition been present? _______________
- What is being done to manage it?
  ____

Do you have neuropathy in your toes or feet? Y/N

- How long has this condition been present? _______________
- What is being done to manage it?
  ____

Do you currently use a walking assisted device? **(Check all that apply)**

Cane Walker Wheelchair

How often do you exercise? **(Check all that apply)**

Daily Often Rarely Never

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- What type of exercise is done?
  ____
  ____

Have you had any surgeries anywhere on your head or neck? Y/N

If yes, please provide details:
____
____

Have you had any surgeries on your back, knees, legs, feet, or toes? Y/N

If yes, please provide details:
____
____

Do you have hearing loss? Y/N RIGHT EAR LEFT EAR BOTH EARS

Do you have tinnitus (ear ringing or roaring)? Y/N RIGHT EAR LEFT EAR BOTH

Do you have ear pressure/fullness? Y/N RIGHT EAR LEFT EAR BOTH EARS

Do you quickly see the room spin when exposed to ***EXTREMELY*** loud sounds? Y/N

Have you ever fallen? Y/N

How many times have you fallen in the last year? ____________

Were any of your falls due to your dizziness? Y/N

Have you ever had head trauma? Y/N

Did this result in a diagnosed concussion? Y/N

Approximately when was the last time you had head trauma? _______________

Do you have a history of ***MODERATE TO SEVERE*** neck or back pain? NECK BACK BOTH

Do you currently use or have a history of illicit substance abuse? Y/N

If yes, please provide what substance was or is currently being used:

____

How often and in what amount? ____

If stopped, how long? ____

Do you currently use or have a history of CANNABIS/MARIJUANA use in any form? Y/N

How often and in what amount? ____

If stopped, how long? ____

Do you currently use or have a history of TOBACCO/NICOTINE use in any form? Y/N

How often and in what amount? ____

If stopped, how long? ____

Do you currently use or have a history of ALCOHOL use in any form? Y/N

How often and in what amount? ____

If stopped, how long? ____

Do you have a history of anxiety or depression? Y/N

Is your condition being treated by therapy or medication?

THERAPY MEDICATION BOTH NEITHER

FOR OFFICE USE ONLY:

MRN: ______________________ FIN#: ________________________