



**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 CIRCLING 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? **(Circle all that apply)**

DAILY / WEEKLY / MONTHLY / YEARLY

How long does the dizziness/vertigo last when it occurs? **(Circle 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? \_\_\_\_\_



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? **(Circle 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? **(Circle all that apply)**

- Cane / Walker / Wheelchair

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

- Daily / Often / Rarely / Never



- What type of exercise is done?

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

If yes, please provide details:

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

If yes, please provide details:

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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 EARS

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:

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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#: \_\_\_\_\_