NATURAL PAIN MANAGEMENT AND WELLNESS

Vestibular Rehabilitation Dizziness & Balance Medical History Questionnaire

Please answer the following questionnaire to assist the therapist treating your case. If there are any questions, please ask the receptionist. Thank you!

Name: _____Date:_____
DOB:_____ Gender: _____
Insurance:_____
Address:_____
_____
Phone:_____
Email:_____
Occupation: _____

I. Symptoms

In the box after each symptom, rate the severity of that symptom using a scale of 0-10, with 10 being most severe.

Symptom	1-10	Symptom	1-10	Symptom	1-10	Symptom	1-10
Dizziness		Spinning		Lightheadedness		Rocking/Tilting	
Visual Changes		Headache		Fatigue		Unsteadiness	
Falling		Noise in Ears		Brain Fog		Fainting	
Hearing Loss		Double Vision		Pressure or Pain in Ears		Other:	

II. History of Present Illness

• Problem start date:_____
• Was the problem associated with a related event (i.e. head injury)? Yes No
If yes, please explain:_____
• Was the onset of your symptoms sudden or gradual?
Describe:_____
• Are your symptoms constant or variable (i.e. come and go in spells)
If variable:
The spells occur every # of: _____hours _____ days _____weeks
_____months _____ years
Do you have any warning signs when a spell is about to happen?
_____
Are you completely free of symptoms between spells? Yes No
• Do your symptoms occur when changing positions? Yes No
If yes, check all that apply:
☐ Rolling your body to the left
☐ Rolling your body to the right
☐ Moving from a lying to sitting position
☐ Looking up with your head back
☐ Turning head side to side while sitting/standing
☐ Bending over with your head down
• When symptoms occur, do you need to support yourself to stand or walk? Yes No
If yes, how do you support yourself?_____

• When walking, do you
☐ Veer left
☐ Veer right
☐ Remain straight
• Have you ever fallen as a result of your current problem? Yes No
• Do you have a history of any of the following?
If yes, check all that apply:

☐Migraines	☐Multiple Sclerosis	☐Seizures
☐Neuropathy	☐Macular Degeneration	☐Stroke
☐Panic attacks/Anxiety	☐Concussion	☐Cervical spine arthritis
☐Glaucoma	☐Congestive heart failure	☐Ataxia
☐Parkinson's disease	☐Tumors	☐Diabetes Miletus

• Do you have difficulty hearing? Right Ear Left Ear No
When did this start? _____
• Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? Yes No

III. Prior relevant medical evaluations, diagnostic testing, and treatment:
• Have you seen other healthcare providers for your condition? Yes No
If yes, who?
☐Primary care doctor
☐ENT/HNS doctor
☐Neurologist
☐Cardiologist
☐Emergency Room doctor
☐Physical therapist/Occupational Therapist

Have you had any of the following done for this condition elsewhere?

Test/Therapy	When	Where	Results
ENG/VNG			
CT Scan/MRI			
Rehab (PT/OT)			

Are you currently taking any medications?
_____

IV. Additional Information
Is there any additional information you would like the therapist to know?