FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

Vestibular Questionnaire

Describe the MAJOR problem or reason you are seeing us today:

_____
_____
_____

When did this problem begin and describe in detail, if possible, the circumstances surrounding the start of this issue?

_____
_____
_____

On a scale of 1 (minimal problem) to 10 (unable to function), how severe is the problem:

Today: _____/10 At worst: _____/10

Specifically, do you experience spells of vertigo (a sense of spinning)? Yes No

If yes, how long do these spells last? _____

Is the vertigo:

Spontaneous	Yes	No
Induced by motion	Yes	No
If so please describe: _____		
Induced by position changes:	Yes	No
If so please describe: _____		
Provoked by pressure changes:	Yes	No
Provoked by loud sounds:	Yes	No

Do you experience a sense of being off-balance (disequilibrium)? Yes No

If YES, is the feeling of being off balance:

Spontaneous:	Yes	No
Induced by motion:	Yes	No
Induced by position changes:	Yes	No
Worse with fatigue:	Yes	No
Worse in the dark:	Yes	No
Worse outside:	Yes	No
Worse on uneven surfaces:	Yes	No
Worse on stairs:	Yes	No

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Does the feeling of off-balance occur when:

Lying down	Yes	No
Standing	Yes	No
Sitting	Yes	No
Walking	Yes	No

Check any **associated symptoms or other sensations which accompany your specific problem:**

- Blacking out or fainting when dizzy
- Headaches
- Double or blurry vision
- Numbness in face or extremities
- Weakness or clumsiness arms/legs
- Slurred or difficult speech
- Difficulty swallowing
- Tingling around mouth
- Spots before eyes
- Jerking of the arms and legs
- Confusion or memory loss
- Change in hearing

Check any **triggers that may be linked with your specific problem:**

- Stress
- Menstrual period
- Overwork or exertion
- Noted minutes to 2 hours after eating
- Noted after urinating
- Straining, lifting
- Preceded by cold/flu
- Recent changes in eyeglasses
- Diet
- Loud noises

Do you or have you fallen to the ground? Yes No

If Yes, please describe the last time that you fell and when it occurred:

_____

_____

Do you stumble, stagger or side-step while walking? Yes No

Do you drift to one side while you walk? Yes No

If yes, which side? Left Right

Have you had any tests done for this episode? Yes No

If yes, please list which test and if there were any significant results:

_____

_____

_____

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Have you tried any treatments for this episode? Yes No
If yes, please describe:
_____
_____

Have you had prior bouts of vertigo (spinning) or imbalance before this current episode?
Yes No

If yes, approximately when did these bouts occur, did the symptoms feel the same as what you are feeling with this current episode, and did you receive treatment for prior episodes?
_____
_____
_____

Do you have a history of motion sickness? Yes No
If yes, what provokes it? _____

Do you have:

Cervical problems:	Yes	No
Lumbar problems:	Yes	No
Neuropathy:	Yes	No
Migraine history:	Yes	No
Headaches history:	Yes	No
Weakness or paralysis:	Yes	No
Hearing problems:	Yes	No
Visual problems:	Yes	No
Concussion history:	Yes	No

Have you been in a car accident before? Yes No

If yes, please describe when, any injuries that occurred, and any treatment needed:
_____
_____
_____

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SOCIAL HISTORY

Do you live alone? Yes No
If No, who lives with you? _____

Do you have stairs in your home? Yes No
If yes, how many? _____

Do you smoke? Yes No
If yes, please indicate how much/day _____

Do you drink? Yes No
If yes, please indicate how much _____

Do you have trouble sleeping? Yes No
If yes, do you take medication for it? Yes No

The scale below consists of a number of words that describe different feelings/ and emotions. Read each item and then mark the appropriate answer in the space next to that word using the scale below indicating to what extent you generally feel this way.

That is, how do you feel on a daily basis?

1 Very slightly or not at all	2 A little	3 Moderately	4 Quite a bit	5 Extremely
___interested	___irritable	___ jittery	___ strong	___ nervous
___ enthusiastic	___ distressed	___ alert	___ active	___ excited
___ ashamed	___afraid	___ upset	___ inspired	___ hostile
___ guilty	___ determined	___ proud	___ scared	___ attentive

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CURRENT FUNCTIONAL STATUS

Are you independent in self-care activities?	Yes	No	
Can you drive in the daytime?	Yes	No	
Can you drive at night?	Yes	No	
Are you working?	Yes	No	N/A
Occupation: _____			
Are you on Medical Disability?	Yes	No	
Can you perform all your normal parenting activities?	Yes	No	N/A

Are you able to:

Watch TV comfortably	Yes	No
Read	Yes	No
Go shopping	Yes	No
Be in traffic	Yes	No
Use computer or phone	Yes	No

For this current episode please pick one statement that best describes how you feel:

_____ Negligible symptoms
_____ Bothersome symptoms
_____ Performs usual work duties but symptoms interfere with non-work activities
_____ Symptoms disrupt performance of work and non-work activities
_____ Currently on medical leave or had to change jobs/ leave school because of symptoms