



## Vestibular Questionnaire

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

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

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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
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Induced by motion	Yes	No
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If so please describe: \_\_\_\_\_

Induced by position changes:	Yes	No
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If so please describe: \_\_\_\_\_

Provoked by pressure changes:	Yes	No
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Provoked by loud sounds:	Yes	No
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Do you experience a sense of being off-balance (disequilibrium)?      Yes      No

If YES, is the feeling of being off balance:

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

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

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

- |                                                                |                                                       |
|----------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Stress                                | <input type="checkbox"/> Straining, lifting           |
| <input type="checkbox"/> Menstrual period                      | <input type="checkbox"/> Preceded by cold/flu         |
| <input type="checkbox"/> Overwork or exertion                  | <input type="checkbox"/> Recent changes in eyeglasses |
| <input type="checkbox"/> Noted minutes to 2 hours after eating | <input type="checkbox"/> Diet                         |
| <input type="checkbox"/> Noted after urinating                 | <input type="checkbox"/> 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:

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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:

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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?

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



**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