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