Rehabilitation Services
Patient History Questionnaire – Vestibular

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION
I am currently:  □ Employed  □ Employed with restrictions  □ On medical leave  □ Not employed
Employer: ______________________________________  Occupation: ________________________
Interests/hobbies/exercise: ____________________________________________________________
Is there anyone who can assist you with doing home exercises or activities if needed?  □ Yes  □ No
Will you have any problems attending therapy sessions?  □ No  □ Yes  If yes, please describe:
_________________________________________________________________________________

Next scheduled Dr appointment(s):  Date__________  Physician__________________
                                  Date__________  Physician__________________

KEY QUESTIONS ABOUT YOUR CONDITION
1. Please ✓ all symptoms you have experienced with your current problem:
   □ Lightheadedness  □ Nausea/vomiting  □ Vision changes  □ Objects spinning or turning
   around you
   □ Blacking out  □ Pressure in head/ears  □ Falls
   □ Loss of consciousness  □ Hearing loss  □ Loss of balance when walking  □ Sensation that you are
   spinning inside
   □ Headache  □ Noise in ears  □ Numbness in face, arms, or legs
   □ Headache  □ Noise in ears  □ Numbness in face, arms, or legs

2. Since the time you first experienced your symptoms are they:  □ better  □ worse  □ same

3. Describe what happened _________________________________________________________

4. Previous episodes?  □ No  □ Yes  Dates(s) or how often: ____________________________

5. Any previous therapies for this problem?  □ No  □ Yes, please explain ______________________

6. Are you dizzy:  □ all the time  or  □ occurs in attacks, lasting ______________________

7. Please mark the intensity level of your symptoms with an X along the following lines:
   What is the intensity of your symptoms at rest?
   None   Severe
   ________________________________   ________________________________
   What is the intensity of your symptoms with activity?
   None   Severe
   ________________________________   ________________________________

8. Are you experiencing any pain?  □ No  □ Yes, please explain ______________________________

9. Does change of position make you dizzy?  □ No  □ Yes, please ✓ all activities that apply:
   □ Turning over in bed  □ Bending over to put on shoes
   □ Sitting upright after laying down  □ Reaching or looking above head
   □ Laying down in bed at night
10. Can you do anything to make dizziness/loss of balance better?  □ No  □ Yes, please explain ________________________

11. Anything specific make it worse?  □ No  □ Yes, please explain ________________________

12. What everyday activities are you having trouble doing because of this problem? ________________________

GENERAL HEALTH
13. At the present time, would you say that your health is:  □ Excellent  □ Very good  □ Fair  □ Poor

14. What is your: Height _______ Weight _______?

15. Medical conditions you have or have had. (check all that apply)
   □ Head Injury  □ Blood clots  □ Sexually transmitted disease
   □ Neck injury/problem  □ Vascular disease  □ HIV/AIDS
   □ Heart disease/pacemaker  □ Stroke  □ Cancer (type) ________________________
   □ High blood pressure  □ Arthritis  □ Recurrent ear infections
   □ Diabetes  □ Hearing loss  □ Impaired vision  Glasses  □ Yes  □ No
   □ Lung/breathing problems  □ Hearing Aids  □ Panic attacks/anxiety
   □ Other ________________________

16. Are you experiencing any physical abuse?  □ Yes  □ No

17. Surgical & Invasive Procedure(s) you have had: (check all that apply, include date if able)
   □ Ear surgery  □ Spinal surgery  □ ________________________
   □ Joint replacement  □ Eye surgery  □ ________________________

18. Uncontrolled leakage of urine?  □ Yes  □ No

19. Loss of bowel control?  □ Yes  □ No

20. Is there any chance you might be pregnant?  □ Yes  □ No

21. Do you smoke?  □ Yes  □ No  Packs per day ______

22. Do you drink alcohol?  □ Yes  □ No  Drinks per week ______

23. Are you on a special diet?  □ Yes  □ No  Specify ________________________

24. Are you taking any medications (prescription, over the counter, herbal preparations)?  □ Yes  □ No  If yes, please list or □ see attached
    ________________________
    ________________________
    ________________________
    ________________________

25. Do you have any allergies (eg. Adhesives, latex, cortisone)?  □ Yes  □ No  If yes, please list with any reactions/treatments:
    Reaction/Treatment: ________________________
    Reaction/Treatment: ________________________

26. For patients 12 years and younger, is immunization/vaccination status current?  □ Yes  □ No

PERSONAL GOALS FOR THERAPY ________________________

To the best of my knowledge, the above information is complete and factual.

Patient Signature ________________________  Date ________________________