MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Vestibular Intake

Patient Name:_____ Date:_____

Please answer the following questions as best as you can as they relate to you:

1. Please describe below your complaint in your own words without using the word dizzy: _____

_____

_____

_____

2. How would you describe your complaint (check all that apply): ☐Dizziness ☐Vertigo ☐Unsteadiness ☐Giddiness ☐Lightheadedness Other:_____

3. Have you seen anyone else for this present complaint? ☐No ☐Yes. If yes, please complete below.

Who have you seen?_____

What treatments have you received? _____

What were the outcomes? _____

4. Have you ever experienced this type of problem before? ☐No☐ Yes. If yes, please complete below.

When & how many times did you have these dizzy spells?_____

Did you see anyone for your past dizziness? _____

What treatments did you receive? _____

What were the outcomes? _____

5. Do you ever have any of the following sensations:

Spinning in circles? ☐No ☐Yes, then describe the direction? _____

Falling to one side? ☐No ☐Yes, then describe which side? _____

The world is spinning around you? ☐No ☐Yes, then describe the direction? _____

You are spinning around the world? ☐No☐Yes, then describe the direction? _____

6. Because of this present problem, have you had any falls? ☐No ☐Yes.

Have you injured yourself from falling? ☐No ☐Yes, explain: _____

7. The following questions refer to a typical "dizzy spell."

When did you notice your first dizzy spell (i.e. date)? _____

Please describe in your own words where you were & how your first dizzy spell came on: _____

_____

Were you taking any medication, over the counter or prescribed, at the time that these symptoms began? ☐No ☐Yes. If yes, describe: _____

Does anything trigger the onset of your dizzy spells? ☐No ☐Yes, then explain: _____

Did you have a recent cold or flu prior to your recent dizzy spells? ☐No ☐Yes

Do these dizzy spells come in attacks? ☐No ☐Yes

How often do these dizzy spells occur? _____

How long do these dizzy spells last? _____

What time of day do these dizzy spells occur? _____

Are you completely free of your dizziness between attacks? ☐No ☐Yes
Does you dizziness occur mainly when you sit-up or stand-up quickly? ☐No ☐Yes
Are there certain positions that you are mainly dizzy in? ☐No ☐Yes If yes, describe:_____
Are you dizzy even when lying down? ☐No ☐Yes
Do you have difficulty getting into bed? ☐No ☐Yes
Does rolling over in bed worsen your present problem? ☐No ☐Yes
Do fast head movements increase your present problem? ☐No ☐Yes
Do you have difficulty reading? ☐No ☐Yes
Does looking up make your dizzy spells worse? ☐No ☐Yes
Does walking down the isle of a supermarket make your problem worse? ☐No ☐Yes
Do you have trouble walking in the dark? ☐No ☐Yes
Are the dizzy spells better when you lie or sit perfectly still? ☐No ☐Yes
Does anything alleviate your dizzy spells? ☐No ☐Yes, then explain: _____
Does anything make them worse? ☐No ☐Yes, then explain:_____

8. The next questions relate to other sensations or symptoms you may have.
Do you also get nauseated when having a dizzy spell? ☐No ☐Yes
Do you ever black out or faint with your dizzy spells? ☐No ☐Yes
Do you experience fullness, pressure, or ringing in your ears? ☐No ☐Yes. If yes, when: _____
Have you experienced pain or discharge from your ears? ☐No ☐Yes. If yes, when: _____
Have you had any hearing loss? ☐No ☐Yes
Have you had any severe or recurrent headaches? ☐No ☐Yes.
Have you noticed any visual problems such as blurry or double vision? ☐No ☐Yes.
Have you noticed any of the following: ☐Clumsiness? ☐Uncoordinated movement. ☐Trouble with smooth movement of arms. ☐Trouble with smooth movement of legs. ☐None of the above.
Do you stumble, stagger, or side-step when walking? ☐No ☐Yes.
Do you drift to one side when you walk? ☐No ☐Yes. If yes, then which side? _____
Are you having any problems with concentration or memory loss? ☐No ☐Yes
Have you had any recent head trauma? ☐No ☐Yes. If yes please explain: _____
Did you experience any trauma around or before the time that your dizzy spells began? ☐No ☐Yes.
If yes please explain: _____

9. These questions relate to how your dizziness or unsteadiness relates to your daily life:
Does this problem make you frustrated? ☐Somewhat frustrated. ☐Moderately frustrated. ☐Extremely frustrated.
Does this problem restrict your travel? ☐No ☐Yes.
Does it embarrass you in front of others? ☐No ☐Yes
Are your symptoms affecting your social activity? ☐No ☐Yes
Do you have to avoid heights? ☐No ☐Yes
Are you afraid people might think you are intoxicated or drunk? ☐No ☐Yes
Are you able to act independently in self care activities (e.g. hygiene)? ☐No ☐Yes.
Is this problem affecting your ability to work? ☐No ☐Yes. If yes, how so:_____

10. What do you think is the reason you are having these dizzy spells? _____

Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctors

Patient's signature (or guardian's signature): _____ Date: _____

Signature of translator or person assisting with this form (if any): _____

Printed Name of Said Person: _____ Date: _____

Doctor's Notes: _____Doctor's Initials: _____

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