Canyon Physical Therapy and Aquatic Rehabilitation
INITIAL PATIENT QUESTIONNAIRE
Vestibular/Dizziness

Name_____ Date_____ D.O.B._____
Height_____ Weight_____ Sex: ☐Male ☐Female ☐Right Handed ☐Left Handed

Chief Complaint(Condition/Symptoms):_____
_____
Description of Complaint:_____
_____
Date of Onset:_____ Imaging Results:_____
Have you had Physical Therapy for this or other conditions this year? ☐Yes ☐No Number of visits: _____

Treatments related to this complaint (ie. Physical Therapy, Chiropractic, injections….)

Treatment	Start Date	End Date	Outcome

I. When you are dizzy, do you experience any of the following sensations? Circle the terms that describe your feelings most accurately.

Light headedness
Headache
Nausea or vomiting
Pressure in the head
Spinning
Sensation that you are turning
Sensation that things are turning around you
Dizziness occurs in attacks
Disequilibrium – sensation of falling to one side
Other (please specify):_____

II. Please fill in the blank spaces:

1) Is your dizziness constant? _____
2) Does it come in attacks? _____
3) How often do the attacks occur? _____
4) How long are the attacks? _____
5) When did the dizziness first occur? _____ Are you getting better? _____
6) Symptoms are provoked by: (please check one answer for each question)

	Not at all	Some	Severely
Turning over in bed, left or right			
When lying flat			
Bending over or looking up			
Standing upright			
Rapid head movements			
Walking in a dark room			
Walking on uneven surfaces			
Loud noises			
Cough, sneeze, strain, laugh, blowing up balloons			
Movement of objects in the environment			
Moving your eyes while your head is still			
Wide open spaces			
Tunnels, bridges, supermarkets, heights			

7) Have you ever stumbled or fallen because of dizziness? _____

8) Do you know anything that will:
   Stop your dizziness or make it better? If so, what? _____
   Make your dizziness worse? If so, what? _____
   Bring on an attack? If so, what? _____
9) Did you ever injure your head? _____
10) Do you take any medications regularly?

Allergy pills/Antihistamines?	Yes/No	High blood pressure meds?	Yes/No
Decongestants?	Yes/No	Tranquilizers?	Yes/No
Aspirin?	Yes/No	Pain pills?	Yes/No
Dizziness pills?	Yes/No	Antibiotics?	Yes/No

11) History: Have you ever had…(please check one answer for each question)

	Yes	No
Ear infections		
Difficulty with hearing		
Pain, fullness, popping or pressure in the ear		
Ringing in ears (called tinnitus) if Yes – is it left or right or both ears steady, pulsating high or low pitched		
Pain, pins/needles, numbness, weakness of face		
Crossed or lazy eyes		
Vision problems		
Intravenous antibiotics or chemotherapy		
Migraines		
Motion sickness		
Neck or back discomfort or injury		
Heart problems. Family history?		
High blood pressure. Family history?		
Diabetes. Family history?		
A motor vehicle accident		
Falls		

12) Do you use tobacco in any form? _____
13) Have you worked in a noisy environment? How long? _____

III. Vertigo Functional Level Scale

Check the **best choice** that best applies regarding your current state of overall function, not just during attacks:

_____ 1. My dizziness has no effect on my activities at all.

_____ 2. When I am dizzy I have to stop what I am doing for a while, but it soon passes and I can resume activities. I continue to work, drive, and engage in any activity I choose without restriction. I have not changed any plans or activities to accommodate for my dizziness.

_____ 3. When I am dizzy, I have to stop what I am doing for a while, but it does pass and I can resume activities. I continue to work, drive, and engage in most activities I choose, but I have had to change some plans and make some allowance for my dizziness.

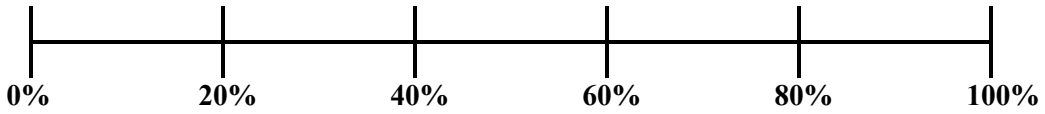
_____ 4. I am able to work, drive, travel, take care of a family, or engage in most activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.

_____ 5. I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited. I am disabled.

_____ 6. I have been disabled for 1 year or longer and/or I receive compensation (money) because of my dizziness or balance problem.

IV. Multidimensional Dizziness Inventory

In the last 6 months what percentage of the time has dizziness interfered with your activities?



Instructions. Please answer the following questions about your dizziness and how it affects your life. Read each question and then circle a number on the scale under that question to indicate how that question applies to you.

1) Rate the level of your dizziness at the present moment.

1	2	3	4	5
none	slight	moderate	quite a bit	extreme

2) Since the time your dizziness began, how much has your dizziness changed your ability to work?

1	2	3	4	5
none	slightly	moderately	quite a bit	extremely

3) How much has your dizziness changed your ability to do household chores?

1	2	3	4	5
none	slightly	moderately	quite a bit	extremely

4) Does your dizziness significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?

1	2	3	4	5
none	slightly	moderately	quite a bit	extremely

5) To what extent does dizziness prevent you from driving your car?

1	2	3	4	5
none	slightly	moderately	quite a bit	extremely

/25= %

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