VESTIBULAR ASSESSMENT - QUESTIONNAIRE

Name: _____ **Date:** _____

Briefly list the problems you would like to see addressed today? _____

When did the problem(s) begin _____
Have you been in an accident? YES NO If yes, when did it occur? _____
If yes, please briefly describe the accident_____
Have you ever been diagnosed with a concussion? _____
Are you taking any medications? _____

Vertigo is a specific form of dizziness where you experience the illusion of movement in the environment, like the 'bed spins'

Have you ever experienced a sustained (longer than 2 minutes) period of spinning vertigo? YES NO
If yes, when did that occur? _____
How many episodes of vertigo have you experienced? _____
With the vertigo, did you have nausea and imbalance? _____

Have you experienced shorter spells of spinning vertigo YES NO
If YES, how long do these spells last? _____
When was the last time the vertigo occurred? _____
Does the vertigo occur:
Spontaneously with no head movement? YES NO
Induced by head positional changes? YES NO

Do you experience a sense of being off-balance (disequilibrium or dizziness)? YES NO
If YES, is the feeling of being off-balance:
constant all the time YES NO
occurring spontaneously (no movement) YES NO
induced by movement YES NO
worse with fatigue YES NO worse in the dark YES NO
worse outside YES NO worse when on uneven surfaces YES NO

Does the feeling of being off-balance occur when:
lying down YES NO sitting YES NO
standing YES NO walking YES NO

Have you ever fallen (to the ground)? YES NO
If yes, please describe? _____
How often do you fall? _____
Have you injured yourself? _____

Do you stumble, stagger, or side-step while walking? YES NO

Do you drift to one side while you walk? YES NO
If YES, to which side do you drift? Right Left

Name _____ **-2-** **Date**_____

Past Medical History

Do you have:	Diabetes	Yes	No	Heart Disease	Yes	No
	High blood pressure	Yes	No	Headaches (migraines)	Yes	No
	Arthritis	Yes	No	Neck problems	Yes	No
	Back problems	Yes	No	Tinnitus (ear noise)	Yes	No
	Hearing problems	Yes	No	Stroke	Yes	No
	Visual problems	Yes	No	Neurological problems	Yes	No

Social History

Do you live alone?	Yes	No
Do you have stairs in your home?	Yes	No
Do you have trouble sleeping?	Yes	No

The scale below consists of a number of words that describe different feelings and emotions. Read each item and then indicate how you feel on the average using the numbers **1 2 3 4 5**. Mark the number in the space next to the word.

1 **slightly/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

Functional Status

Any increased fatigue? Yes No

Can you drive: In the daytime? Yes No In the night time? Yes No

Are you working Yes No

What type of work are you engaged in? _____ Not applicable

Are you able to:

Watch TV comfortably?	Yes	No	Read hard copy?	Yes	No
Go shopping?	Yes	No	Be in Traffic?	Yes	No
Work on a computer	Yes	No	Be in a noisy place	Yes	No
Scroll on a smart phone?	Yes	No	Multi-task effectively?	Yes	No
Any problems with memory?	Yes	No	Any problems with concentration?	Yes	No

Initial Visit

For the following, please pick the one statement that best describes how you feel?

_____ Negligible symptoms
_____ Bothersome symptoms
_____ Performs usual work duties but symptoms interfere with outside activities
_____ Symptoms disrupt performance of both usual work duties and outside activities
_____ Currently on medical leave or had to change jobs because of symptoms
_____ Unable to work for over one year or established permanent disability with compensation payments