Total Balance PHYSIOTHERAPY

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VESTIBULAR Ax. Date: ______________________

Name: __________________ Age: ________ Occupation: ________________

Describe the major problem or reason you are seeing us: ____________________________
When did the problem begin?: __________________________________

Specifically, do you experience spells of **vertigo**?
(vertigo = do you perceive the environment around you moving)? YES NO
If YES, how long do these spells last? ____________________________
When was the last time the vertigo occurred? ______________________
Is the vertigo:

spontaneous	YES	NO
induced by motion	YES	NO
induced by position changes	YES	NO

Do you experience a sense of **dizziness** (spinning in your head but your surroundings stay stable)
or a sense of being **off balance** (disequilibrium)? YES NO

If YES, is the feeling of dizziness/being off-balance:

constant	YES	NO	worse with fatigue	YES	NO
spontaneous	YES	NO	worse outside	YES	NO
induced by motion	YES	NO	worse in the dark	YES	NO
induced by position changes	YES	NO	worse on uneven surfaces	YES	NO

Does the feeling of dizziness or being off-balance occur when you are:

lying down	YES	NO	sitting	YES	NO
standing	YES	NO	walking	YES	NO

Do you OR have you 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, which side do you drift? Right Left

What medications are you taking for **this problem,** if any? ____________________________

Do you have neck/back problems? YES NO If YES to any, describe:

Do you have headaches? YES NO

Do you have any hearing or
visual problems? YES NO

Have you been in an accident? YES NO If YES, when did it occur? ______________
If YES, please describe ____
____

Social History:

Do you live alone? YES NO
Do you have stairs in your home? YES NO
Do you have trouble sleeping? YES NO

Functional Status

Are you independent in self-care activities: YES NO
Can you drive (please circle) → In the daytime? YES NO In the night time? YES NO
Are you working? YES NO Not applicable
Are you on Medical Disability? YES NO

Are you able to:

Watch TV comfortably?	YES	NO	Read?	YES	NO
Go shopping?	YES	NO	Be in traffic?	YES	NO
Work on a computer?	YES	NO	Be in a noisy place?	YES	NO

Initial Visit

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

______Negligible symptoms (symptoms bother you very little, or not at all)

______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 > one year or on permanent disability with compensation payments

Optional - The scale below helps us to maximize your care. It consists of a number of words that describe different feelings and emotions that you may be experiencing. 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