PATIENT INTAKE

Patient Name: _____ Date of Birth: ___/___/_____ Sex: Male / Female

Provider Name: _____ Appt Date: ___/___/_____

CURRENT SYMPTOMS

Which of the following best describes your symptoms?

o imbalance
o falling more often
o nausea
o world spinning around you
o you feel as if you are spinning; the world is not spinning
o lightheadedness
o other: _____

How long do your symptoms last without stopping?

o seconds o minutes o hours o days o constant

Circle One: How many times per **day** / **week** / **month** / **year** do you have an episode? _____

Did any of the following occur **immediately before your symptom** onset? *(check all that apply)*

o head trauma
o motor vehicle accident
o upper respiratory infection
o change in medication
o a fall
o a virus or infection, e.g., shingles, cold sores, covid-19
o surgery
o stressful event or high-stress
o other: _____

Circle One: Have your symptoms **improved** / **changed** / **stayed** the same since they began?

If Improved or Changed: How so? _____

Does anything make your symptoms better? _____

BALANCE & FALL SYMPTOMS

(Circle Y *for Yes, Circle* N *for No)*

Y N Have you fallen in the past year?

If yes: How many times? _____
If no: Have you experienced "near falls" but you caught yourself? **Y N**

Y N Are you afraid of falling?

Y N Are you veering/leaning while walking? *If **yes**:* Which direction? **right** / **left** / **both**

Y N Do you have neuropathy, numbness, or tingling in your feet or legs?

Y N Has your exercise decreased? *If yes:* Approximately when? _____

Y N Orthopedic injuries/issues? *If yes:* Please explain: _____

DIZZINESS SYMPTOMS

Y N Do you have a history of Migraines? *If **yes**:* When was your most recent Migraine? _____

Do any of the following trigger your symptoms? *(check all that apply)*

o Increased stress
o Skipping a meal
o Not drinking enough water
o Changes in weather
o Certain foods: _____

Do any of the following **accompany** or occur **immediately prior** to an episode of your symptoms? *(check all that apply)*

o Headaches
o Neck Pain
o Nausea/Vomiting
o Shimmers, Sparkles, or flashing lights in your vision
o Hearing Changes **right ear** / **left ear** / **both ears**
o Fullness in your ear(s): **right ear** / **left ear** / **both ears**
o Ringing in your ear(s): **right ear** / **left ear** / **both ears**
o Sensitivity to *(circle all that apply)*
light / **sound** / **smell** / **patterns** / **screens** / **motion**

Y N My dizziness is intense but only lasts for seconds or minutes

Y N I get dizzy when I turn over in bed

Y N I get short-lasting, spinning dizziness that happens when I bend down to pick something up

Y N I get short-lasting, spinning dizziness that happens when I go from sitting to lying down

Y N I can trigger my dizzy spells by placing my head in certain positions

Y N I have had a single severe spell of spinning dizziness that lasted for hours to a day

Y N After my big episode of dizziness, I could not walk for days without falling over

Y N I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu

Y N I had hearing loss in one ear at the same time I had the long episode of spinning dizziness

Y N I have spells where I get dizzy, and it is difficult for me to breathe

Y N I feel dizzy all of the time

Y N I am anxious most of the time

Y N I am bothered by patterns, screens, e.g., supermarkets

Y N My symptoms increase when I go from laying to sitting or sitting to standing

Y N When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

Y N When I cough or sneeze, I get dizzy

Y N I get dizzy when I strain to lift something heavy

Y N When I speak, my voice sounds abnormally loud to me

Y N My dizziness is provoked with head movements (up/down and/or right/left)

Y N My head is heavy like a bowling ball

Y N I have a headache that is in or starts in the back of my head

MEDICAL HISTORY

o anxiety/stress
o depression
o motion sickness
o cardiac problems
o respiratory problems
o thyroid dysfunction
o diabetes
o high blood sugar
o low blood sugar
o high blood pressure
o low blood pressure
o Meniere's disease
date of diagnosis _____
o stroke / TIA
o eye/vision concerns

HEARING HEALTH HISTORY

Y N Do you have hearing loss?

*If **yes**:* Which ear? **right ear**, **left ear**, **both ears** *(circle one)* *If **yes**:* Was it sudden? **Y N**

Y N Do you wear hearing aids?

Y N I am experiencing ear **pain** / **ringing** / **drainage** / fullness (*circle all that apply)*

If yes: Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

Y N I have had ear surgery? **right ear** / **left ear** / **both ears** *(circle all that apply)*

*If **yes**:* **acoustic neuroma** / **mastoid** / **cochlear implant** / other: _____

IF APPLICABLE: FEMALE HORMONAL HISTORY

Circle One: Are you **pre** / **peri** / **post** menopausal?

Y N Have you had a hysterectomy? *If **yes**:* When? _____

Y N Have you had any changes to your contraceptives? *If **yes**:* When? _____

Y N Do you have known hormonal imbalance? *If **yes**:* Are you being treated for this issue? **Y N**