STAR PHYSICAL THERAPY

Vestibular Patient Questionnaire

Patient Name: ____ **Date:** __________________

1. **Do you experience:** *(Check one):*
   Dizziness Change in balance/Unsteadiness Both

2. **How would you describe what you experience?** *(Check all that apply):*
   Unsteadiness with walking
   Tendency to fall
   Light-headedness
   Sensation of spinning
   Ringing/Noise in your ear(s)
   Change in your hearing
   Pain in your ear(s)
   Fullness in your ear(s)
   Nausea/Vomiting
   Fatigue
   Clumsiness
   Rocking sensation (as if on a boat)
   Difficulty walking straight
   Blacking out
   Loss of consciousness
   Other: ______________________
   ____
   ____

3. **How long have you been experiencing these symptoms?**

4. **Were you sick or did you experience any trauma prior to the onset of these symptoms?** *If yes, please explain:*

5. **When do you experience these symptoms?** *(Check all that apply):*
   Dark/Dimly lit areas
   Driving
   Morning
   Evening
   Mid-day
   Constantly
   In open spaces
   Getting in/out of bed
   Walking on uneven surfaces
   Watching TV/computer
   Using escalator/elevator
   After exerting/exercising

6. **How often do you experience these symptoms?** *(Check one):*
   All day Intermittent throughout the day Weekly Monthly

7. **If you experience dizziness, how long does it last?** *(Check one):*
   Seconds Minutes Hours Days Weeks

8. **Does anything help?** *(Check all that apply):*
   Change in position Medication Exercises Diet Other: ______________________

9. **Do you have vision problems?** *If yes, explain:*

10. **When was your last eye exam?**

11. **Have you ever had testing for your inner ear?** *(i.e.: ENG, Caloric test -hot/cold air/liquid in your ears)*

12. **Have you ever consulted a Neurologist or an Otolaryngologist (ENT)?** *If yes, please explain*:

13. **Do you have any additional comments?**