

PATIENT INTAKE

Patient Name: _____

Date of Birth: __/__/____

Sex: Male / Female

Provider Name: _____

Appt Date: __/__/____

CURRENT SYMPTOMS

Which of the following **best describes your symptoms**?

- | | |
|---|--|
| <input type="radio"/> imbalance | <input type="radio"/> you feel as if you are spinning; the world is not spinning |
| <input type="radio"/> falling more often | <input type="radio"/> lightheadedness |
| <input type="radio"/> nausea | <input type="radio"/> other: _____ |
| <input type="radio"/> world spinning around you | |

How long do your symptoms last **without stopping**?

- seconds minutes hours days 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*)

- | | |
|---|--|
| <input type="radio"/> head trauma | <input type="radio"/> a virus or infection, e.g., shingles, cold sores, covid-19 |
| <input type="radio"/> motor vehicle accident | <input type="radio"/> surgery |
| <input type="radio"/> upper respiratory infection | <input type="radio"/> stressful event or high-stress |
| <input type="radio"/> change in medication | <input type="radio"/> other: _____ |
| <input type="radio"/> a fall | |

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*)

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

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

- Headaches
- Hearing Changes **right ear / left ear / both ears**
- Neck Pain
- Fullness in your ear(s): **right ear / left ear / both ears**
- Nausea/Vomiting
- Ringing in your ear(s): **right ear / left ear / both ears**
- Shimmers, Sparkles, or flashing lights in your vision
- 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

- | | | |
|--|---|---|
| <input type="radio"/> anxiety/stress | <input type="radio"/> thyroid dysfunction | <input type="radio"/> low blood pressure |
| <input type="radio"/> depression | <input type="radio"/> diabetes | <input type="radio"/> Meniere's disease
<i>date of diagnosis</i> |
| <input type="radio"/> motion sickness | <input type="radio"/> high blood sugar | _____ |
| <input type="radio"/> cardiac problems | <input type="radio"/> low blood sugar | <input type="radio"/> stroke / TIA |
| <input type="radio"/> respiratory problems | <input type="radio"/> high blood pressure | <input type="radio"/> 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*