PATIENT INTAKE

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

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

CURRENT SYMPTOMS

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

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

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)*

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

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

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

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

- ○ anxiety/stress
- ○ depression
- ○ motion sickness
- ○ cardiac problems
- ○ respiratory problems
- ○ thyroid dysfunction
- ○ diabetes
- ○ high blood sugar
- ○ low blood sugar
- ○ high blood pressure
- ○ low blood pressure
- ○ Meniere's disease
  date of diagnosis
  _____
- ○ stroke / TIA
- ○ 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**