

VESTIBULAR REHABILITATION – INITIAL QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Referring Physician: _____ City/State: _____

Describe the major problem or reason for your visit: _____

When did this problem begin? _____

Specifically, do you experience spells of vertigo (a sense of spinning)? YES NO

If YES, how long do these spells last? _____

When was the last time the vertigo occurred? _____

Is the vertigo: (check all those that apply)

Spontaneous Induced by motion Induced by position changes

Do you experience a sense of being off-balance (disequilibrium)? YES NO

If YES, is the feeling of being off-balance: (check all those that apply)

Contant Spontaneous Induced by motion Induced by position changes Worse with fatigue
 Worse outside Worse in the dark Worse on uneven surfaces

Does the feeling of being off-balance occur when (check all those that apply):

Lying down Sitting Standing Walking

Do you or have you fallen to the ground? YES NO Date of last fall: _____

If YES, please describe: _____

How often do you fall? _____

Do you fall because of your dizziness? YES NO

Do you stumble, stagger or side-step while walking? YES NO

Have you injured yourself because of your fall(s)? YES NO

If YES, please describe: _____

PAST MEDICAL HISTORY (check all those that apply):

- | | | | | |
|---|--|---|--|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Pulmonary Problems | <input type="checkbox"/> Weakness | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other visual Problems | |

Have you ever been in an accident? YES NO

If YES, when did it occur? _____

Please describe: _____

What medications do you currently take (Name/dose)? _____

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FUNCTIONAL STATUS:

Functional level of activities before this problem developed? _____

Current functional Status:

Are you independent in self-care activities: YES NO

If NO, Check which things you CANNOT do by yourself:

Dress Bathe Get on and off toilet Prepare simple meal Light house cleaning

Can you drive? YES NO In the nighttime? YES NO

Are you working? YES NO Not applicable

Occupation: _____

For the following, please pick the ONE statement that best describes how you feel:

- Negligible symptoms
- Bothersome symptoms
- Performs usual work/house duties but symptoms interfere with outside activities
- Symptoms disrupt performances of both usual work duties and outside activities
- Currently on medical leave or had to change jobs because of symptoms
- Unable to work for over one year or established permanent disability with compensation payments

The scale below consists of a number of words that describe feelings and emotions. Read each item and then mark the appropriate answer in the space next to the word. Indicate to what extent you generally feel this way. That is, how do you feel on the average. Use the following scale to record your answers:

- 1 Very slightly or not at all
- 2 A little
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

There should be a response for each word:

_____ Interested	_____ Enthusiastic	_____ Excited	_____ Hostile
_____ Irritable	_____ Upset	_____ Ashamed	_____ Guilty
_____ Jittery	_____ Distressed	_____ Afraid	_____ Determined
_____ Strong	_____ Alert	_____ Proud	_____ Scared
_____ Nervous	_____ Active	_____ Inspired	_____ Attentive