Patient Name:_____Date:_____

Vestibular Health History Form (*Page 1*):

Please answer the following questions as best as you can as they relate to you:

1. **Please describe below your complaint in your own words *without* using the word dizzy:**_____
2. **How would you describe your complaint (check all that apply):** Dizziness Vertigo Unsteadiness Giddiness Lightheadedness Other:_____
3. **Have you seen anyone else for this present complaint**? No. Yes. If yes, please complete #1.
   Who have you seen?_____.
   What treatments have you received?_____.
   What were the outcomes?_____.
4. **Have you ever experienced this type of problem before**? No. Yes. If yes, please complete #2.
   When & how many times did you have these dizzy spells?_____.
   Did you see anyone for your past dizziness?_____.
   What treatments did you receive?_____.
   What were the outcomes?_____.
5. **Do you ever have any of the following sensations:**
   Spinning in circles? No. Yes, then describe the direction?_____.
   Falling to one side? No. Yes, then describe which side?_____.
   The world is spinning around you? No. Yes, then describe the direction?_____.
   You are spinning around the world? No. Yes, then describe the direction?_____.
6. **Because of this present problem, have you had any falls**? No. Yes.
   Have you injured yourself from falling? No. Yes, explain:_____.
7. **The following questions refer to a typical "dizzy spell."**
   When did you notice your first dizzy spell (i.e. date)?_____
   Please describe in your own words where you were & how your first dizzy spell came on:_____.
   Were you taking any medication, over the counter or prescribed, at the time that these symptoms began? No. Yes. If yes, describe:_____
   Does anything trigger the onset of your dizzy spells? No. Yes, then explain:_____.
   Did you have a recent cold or flu prior to your recent dizzy spells? No. Yes.
   Do these dizzy spells come in attacks? No. Yes.
   How often do these dizzy spells occur? No. Yes.
   How long do these dizzy spells last?_____
   What time of day do these dizzy spells occur? No. Yes.
   Are you completely free of your dizziness between attacks? No. Yes.
   Does you dizziness occur mainly when you sit-up or stand-up quickly? No. Yes.
   Are there certain positions that you are mainly dizzy in? No. Yes. If yes, describe:_____.
   Are you dizzy even when lying down? No. Yes.
   Do you have difficulty getting into bed? No. Yes.

Doctor's Notes:_____

Does rolling over in bed worsen you present problem? No. Yes.
Do fast head movements increase your present problem? No. Yes.
Do you have difficulty reading? No. Yes.
Does looking up make you dizzy spells worse? No. Yes.
Does walking down the isle of a supermarket make your problem worse? No. Yes.
Do you have trouble walking in the dark? No. Yes.
Are the dizzy spells better when you lie or sit perfectly still? No. Yes.
Does anything ***alleviate*** your dizzy spells? No. Yes, then explain:_____

_____.

Does anything make them ***worse***? No. Yes, then explain:_____

8. The next questions relate to other sensations or symptoms you may have.

Do you also get nauseated when having a dizzy spell? No. Yes.
Do you ever black out or faint with your dizzy spells? No. Yes.
Do you experience fullness, pressure, or ringing in your ears? No. Yes. If yes, when:_____.
Have you experienced pain or discharge from your ears? No. Yes. If yes, when:_____.
Have you had any hearing loss? No. Yes.
Have you had any severe or recurrent headaches? No. Yes.
Have you noticed any visual problems such as blurry or double vision? No. Yes.
Have you noticed any of the following: Clumsiness? Uncoordinated movement. Trouble with smooth movement of arms. Trouble with smooth movement of legs. None of the above.
Do you stumble, stagger, or side-step when walking? No. Yes.
Do you drift to one side when you walk? No. Yes. If yes, then which side?_____.
Are you having any problems with concentration or memory loss? No. Yes.
Have you had any recent head trauma? No. Yes. If yes please explain_____

_____.

Did you experience any trauma around or before the time that your dizzy spells began? No. Yes. If yes please explain:

_____.

9. These questions relate to how your dizziness or unsteadiness relates to your daily life:

Does this problem make you frustrated? Somewhat frustrated. Moderately frustrated. Extremely frustrated.
Does this problem restrict your travel? No. Yes.
Does it embarrass you in front of others? No. Yes.
Are your symptoms affecting your social activity? No. Yes.
Do you have to avoid heights? No. Yes.
Are you afraid people might think you are intoxicated or drunk? No. Yes.
Are you able to act independently in self care activities (e.g. hygiene)? No. Yes.
Is this problem affecting your ability to work? No. Yes. If yes, how so:_____.

10. What do you think is the reason you are having these dizzy spells?_____

Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Schmoe Chiropractic Clinic LLC. Any disclosure is outlined in our privacy policies.

_____Patient's signature (*or guardian's signature*)

_____Date

_____Signature of translator or person assisting with this form (*if any*)

Printed name of said person_____ _____Date

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____