Vestibular Questionnaire

Name _____ Date _____

Reason for today's visit _____

Onset date of symptoms _____

Symptoms related to current condition (circle all that apply)

Headache	Trouble falling asleep	Irritability
Nausea	Excessive sleep	Sadness
Vomiting	Loss of sleep	Nervousness
Balance issues	Drowsiness	More emotional
Dizziness	Light Sensitivity	Numbness
Fatigue	Sound sensitivity	Feeling "slow"
Feeling "foggy"	Difficulty concentrating	Difficulty remembering
Visual problems	Hearing loss	Ears ringing
Neck pain		

Symptoms increase with (circle all that apply)

Rolling in bed	Turning in bed	Walking	Straining
Reading	Lying down to sitting up	Looking up	Looking down
Lying down	Loud noises	Sit to stand	Bending/squatting
Driving	Coughing/sneezing	Other	

How long do symptoms last? <1minute <30 minutes Hours Constant

Have you been treated for this issue prior? Y N If yes, by whom _____

Are you taking prescription or over the counter medications for this issue? Y N

Are you using an assistive devise due to this issue (walker, cane, wheelchair, etc.)? Y N

Is there anything else you would like your physical therapist to know about your condition?

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