Vestibular Questionnaire

Name _____ Date _____

Reason for today's visit _____

Onset date of symptoms _____

Symptoms related to current condition (check 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 (check 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? ☐ <1min ☐ <30 min ☐ 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 device 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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