Balance and Vestibular Center Patient Intake Form

Name: _____ Age: _____ Today's Date:_____

Home Phone: _____ Cell Phone:_____

Email address: _____ Best way to contact: Home__ Cell__ Email___

Describe the major problem or reason you are seeing us:

When did your symptoms begin?_____
Did your symptoms begin gradually____ or suddenly____?
Do you experience any of the following? ____dizziness____ vertigo _____spinning
____ lightheadedness ____nausea ____vomiting
If you have spinning, do you see the room spin or do you feel yourself spin?
____ room spinning ____self spinning
How long do your symptoms last? Seconds___ Minutes___ Hours___ Days___
If your symptoms are episodic, do you feel free of symptoms between episodes? Yes___ No___

	Y	N	If yes, please describe
Do you experience a spinning sensation? What movements or positions cause it?			
Do you experience a feeling of being off balance?			
Are you more off balance in the dark?			
Are you more off balance on uneven surfaces?			
Have you had "near falls?"			
Have you fallen to the ground?			
Have you injured yourself due to your symptoms?			
Do you stumble, stagger, or side-step while walking?			
Do you drift to one side when walking? To the right or left?			

Are you currently experiencing any of the following?

	Y	N		Y	N
Spinning sensation?			Severe or recurrent headaches		
Nausea and/or vomiting			Fainting when dizzy		
Fullness and/or pressure in ears			Lightheadedness		
Ringing in ears			Weakness/clumsiness in arms/legs		
Change in hearing			Confusion/memory loss		
Double, blurry, or jumping or lag in vision			Dizziness when standing up quickly		

Medical History (Check yes or no)

	Y	N		Y	N
Diabetes			Meniere's Disease		
Heart Disease			Head Injury		
Pacemaker/Defibrillator			Seizures		
High or Low Blood Pressure			Stroke		
Arthritis			TIA		
Migraine			Back Trouble		
Depression			Whiplash or neck trouble		
Anxiety			Motion sensitivity		
Hearing Problems			Visual problems		
Cancer			Parkinson's Disease		
Breathing trouble			Other (please explain)		

Have you had any of the following?

	Y	N	Date		Y	N	Date
Ear surgery				Heart Surgery			
Neck surgery				CT Scan			
Back surgery				VNG			
Leg surgery				MRI			

Have you been in an accident? Yes___ No___
If yes, describe_____

What medications do you take? _____
_____
_____

Have you taken any of the following medications for your dizziness/imbalance?

	Y	N		Y	N
Meclizine (Antivert)			Diphenhydramine (Benadryl)		
Scopolamine (Transderm Scop patch)			Dimenhydrinate (Dramamine)		
Diazepam (Valium)					

Social History

Occupation_____
Do you have stairs in your home? Yes___ No___ If so, how many? _____
Do you smoke? Yes ___ No___ If yes, how much per day_____
Do you drink alcohol? Yes___ No___ If yes, please indicate how much_____
What recreational activities do you do on a regular basis? _____
_____
What are your goals for therapy?_____
_____

Patient signature: _____ Date: _____