FYZICAL
Therapy & Balance Centers
"Spelled Different Because We Are Different"

Evaluation Questionnaire

Patient Name _____ Date: _____

1. When did your symptoms begin? _____

2. Describe what you are experiencing.

   Spinning/Rotation (Vertigo) ☐ Lightheaded ☐ Off balance ☐ Passing out/fainting

   ☐ Drunk feeling (Ataxia) Other: _____

3. How long do your symptoms last? _____

   ☐ Few seconds ☐ Seconds to minutes ☐ Minutes to several hours

   ☐ Hours to days ☐ Continuous ☐ Other: _____

4. How many episodes of Vertigo have you had?

   ☐ Single ☐ Multiple ☐ Never had vertigo

5. What things have been associated with your episodes?

   ☐ Altered head positions ☐ Rapid Ascents Neck extension ☐ ☐ Salty foods ☐ Headaches

   ☐ Loud sounds ☐ Changes in ear pressure ☐ Rolling over in bed ☐ Migraines ☐ Pain
   Stress

6. What other symptoms do you get around the time of dizzy attacks?

   ☐ Hearing loss ☐ Tinnitus ☐ Aural fullness Headaches ☐ Facial numbness ☐ Anxiety

   ☐ Nausea/vomiting ☐ Changes in vision ☐ Muscle weakness ☐ Pain Other: _____

7. I have the following medical problems:

   ☐ Diabetes ☐ Strokes ☐ High blood pressure ☐ Cardiovascular ☐ Back/neck problems
   ☐ Ear surgery

   ☐ Visual difficulty ☐ Seizures ☐ Migraines ☐ MS ☐ Anxiety/Depression ☐ Cancer Motion sickness

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8. Are there any activities you are unable to do because of your symptoms?

   _____

   _____

   _____

9. Have the symptoms changed since the first episode? ☐Yes ☐No

   If yes: ☐Better ☐Worse ☐Shorter ☐Longer ☐More severe ☐Less severe

10. If you have had any falls in the last year, how many falls? _____

11. What were the circumstances of the falls in the last year, if there were any falls? _____

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