



Vestibular Rehabilitation Program
New Patient History Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

1. Of the symptoms you experience, which one or two symptoms do you consider to be your primary problem? \_\_\_\_\_

2. Please rate the intensity of your symptoms, on average.

0 1 2 3 4 5 6 7 8 9 10

None Very weak Moderate Very Strong
Intolerably Strong

3. How many episodes of your symptoms do you experience each day, on average? \_\_\_\_\_

4. How long does a typical episode / attack last? \_\_\_\_\_

5. What percentage of each day are you free from symptoms? \_\_\_\_\_

6. How many days of the week do you have symptoms on average? \_\_\_\_\_

7. What time of the day do you generally feel best? \_\_\_\_\_

8. What time of the day do you generally feel worse? \_\_\_\_\_

Describe the history of this particular condition

1. When did it begin (month / year)? \_\_\_\_\_

2. How did it begin (trauma / illness, etc.)? \_\_\_\_\_

3. Has it improved or worsened since then? Describe. \_\_\_\_\_

4. Have you had surgeries related to it? If yes, please describe. \_\_\_\_\_

5. What medical tests have you had related to this problem?



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DATE

RESULT

_____	_____	_____
_____	_____	_____
_____	_____	_____

- 6. Do you have a history of vision problems? (crossed eye, lazy eye, poor vision, etc) \_\_\_\_\_  
\_\_\_\_\_
- 7. Do you have glasses? Are they new? \_\_\_\_\_  
\_\_\_\_\_
- 8. Do you have any hearing problems? Describe. \_\_\_\_\_  
\_\_\_\_\_
- 9. Have you had therapy for this condition? If yes, please describe therapy & results. \_\_\_\_\_  
\_\_\_\_\_

### Social Information

- 1. What is your current living situation?  
 1 Storey House (Floor # \_\_\_\_\_)     
  2 Storey House     
  Apartment  
 Other (Describe) \_\_\_\_\_  
 \_\_\_\_\_
- 2. Whom do you live with?  
 Alone     
  Spouse     
  Friend     
  Paid Assistant  
 Other (Describe) \_\_\_\_\_  
 \_\_\_\_\_
- 3. Present employment situation?      Occupation \_\_\_\_\_  
 \_\_\_\_\_  
 Employed \_\_\_ Full time    \_\_\_ Part time       Off work due to symptoms  
 Full time homemaker       Retired       Other \_\_\_\_\_  
 \_\_\_\_\_

### Physical Activity Level

- 1. What was your physical activity level prior to onset of your symptoms? (Regular exercise program, sports participation, etc.) \_\_\_\_\_  
\_\_\_\_\_
- 2. What is your physical activity level today? \_\_\_\_\_  
\_\_\_\_\_



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3. Do you sometimes lose your balance (trip / stumble)? \_\_\_\_\_Yes \_\_\_\_\_No
- a. If yes, how many times per day / week / month? \_\_\_\_\_Times per \_\_\_\_\_  
\_\_\_\_\_
4. Have you fallen in the last 2 years? \_\_\_\_\_Yes \_\_\_\_\_No
- a. If yes, when were your 3 most recent falls? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- b. Describe your most recent fall:
- How did it occur? \_\_\_\_\_
  - \_\_\_\_\_Indoors \_\_\_\_\_Outdoors
  - Dizzy during fall? \_\_\_\_\_Yes \_\_\_\_\_No
  - Injured due to the fall? \_\_\_\_\_Yes \_\_\_\_\_No