

**VESTIBULAR REHABILITATION PROGRAM
SYMPTOM CHECKLIST**

Name: _____
ate: _____

Please circle the severity of each of the following symptoms you experience.

A. <u>PERCEPTION OF MOTION</u>	<u>Severe</u>	<u>Moderate</u>	<u>Mild</u>	<u>None</u>
1. Dizziness	1	2	3	4
2. Vertigo (spinning of self or environment)	1	2	3	4
3. Light-headedness (sense of nearly blacking out)	1	2	3	4
4. Unsteadiness (wanting to "hold on" for balance)	1	2	3	4
5. Objects around you are moving/bouncing	1	2	3	4
Other (describe): _____				

B. <u>AUDITORY SENSATION</u>	<u>Severe</u>	<u>Moderate</u>	<u>Mild</u>	<u>None</u>
1. Difficulty hearing (left/right/both)	1	2	3	4
2. Ringing in ears (left/right/both)	1	2	3	4
3. Pressure or fullness in ears (left/right/both)	1	2	3	4
4. Discharge from ears (left/right both)	1	2	3	4
5. Loudness intolerance	1	2	3	4
Other (describe): _____				

C. <u>VISUAL SENSATION</u>	<u>Severe</u>	<u>Moderate</u>	<u>Mild</u>	<u>None</u>
1. Double vision	1	2	3	4
2. Blurry vision	1	2	3	4
3. Cross eyed/lazy eye	1	2	3	4
4. Intolerance of sun or fluorescent lights	1	2	3	4
5. Difficulty with mini-blinds	1	2	3	4
Other (describe): _____				

D. <u>OTHER</u>	<u>Severe</u>	<u>Moderate</u>	<u>Mild</u>	<u>None</u>
1. Tremor or shakiness	1	2	3	4
2. Twitching or weakness of face	1	2	3	4
3. Numbness of face	1	2	3	4
4. Difficulty swallowing/chewing	1	2	3	4
5. Difficulty with coughing/sneezing	1	2	3	4
6. Headaches	1	2	3	4
7. Nausea/vomiting	1	2	3	4
8. Sweating/cold feelings	1	2	3	4
9. Fainting/loss of consciousness	1	2	3	4
10. Difficulty sleeping	1	2	3	4
11. Heat or cold intolerance	1	2	3	4
12. Alcohol or food intolerance	1	2	3	4
13. Poor concentration	1	2	3	4
14. Excessive stress/anxiety	1	2	3	4
15. Depression/frustration	1	2	3	4

Scoring (for department use only)

Number of items checked	_____	_____	_____	_____
Weighted Score (multiply by item value)	_____	_____	_____	_____
Total summed score (Sum of weighted scores)	_____			
Divided by total possible score (100 or number of items x 4)	÷ _____			
Total percentage score				