



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?

Table with 3 columns: TEST, DATE, RESULT

6. Do you have a history of vision problems? (crossed eye, lazy eye, poor vision, etc) _____



PROVIDENCE

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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-Story House _____ 2-Story House _____ Apartment (Floor #____)
_____ 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? _____
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

VESTIBULAR REHABILITATION PROGRAM

FUNCTIONAL ACTIVITIES CHECKLIST

Name: _____

Date: _____

Please circle the level of difficulty you have with each of the following activities, because of your symptoms.

<u>ACTIVITIES</u>	<u>Unable to Do</u>	<u>Moderate Difficulty</u>	<u>Mild Difficulty</u>	<u>No Difficulty</u>	<u>Not Applicable (didn't perform prior to symptoms)</u>
A. <u>HOUSEHOLD</u>					
*1. Head movement (look up, turn head)	0	1	2	3	N/A
2. Turning over in bed	0	1	2	3	N/A
3. Bending over	0	1	2	3	N/A
4. Standing up	0	1	2	3	N/A
5. Reach up over head	0	1	2	3	N/A
*6. Walk around house in dark	0	1	2	3	N/A
7. Read a book/magazine	0	1	2	3	N/A
8. Make the bed	0	1	2	3	N/A
9. Prepare a meal	0	1	2	3	N/A
10. Wash & put away dishes	0	1	2	3	N/A
11. Light housework (dust, sweep, etc.)	0	1	2	3	N/A
12. Lift/carry groceries	0	1	2	3	N/A
13. Vacuum	0	1	2	3	N/A
Do Laundry	0	1	2	3	N/A
Work in the garden/mow the lawn	0	1	2	3	N/A
16. Walk up/down stairs (1 flight)	0	1	2	3	N/A
17. Walk one block distance	0	1	2	3	N/A
B. <u>COMMUNITY</u>					
*18. Walk outdoors on uneven surfaces	0	1	2	3	N/A
19. Walk on ramps/hills or inclines	0	1	2	3	N/A
20. Walk on grass/dirt or gravel	0	1	2	3	N/A
21. Walk on a busy street	0	1	2	3	N/A
22. Walk outdoors in wide open spaces	0	1	2	3	N/A
23. Shop in grocery store	0	1	2	3	N/A
*24. Walk in mall/crowded store	0	1	2	3	N/A
25. Walk one mile distance	0	1	2	3	N/A
26. Ride an elevator/escalator	0	1	2	3	N/A
27. Ride in a car	0	1	2	3	N/A
28. Drive a car	0	1	2	3	N/A
29. Go out to eat in a restaurant	0	1	2	3	N/A
30. Go to a movie	0	1	2	3	N/A
31. Go to park or beach	0	1	2	3	N/A
32. Vigorous exercise (jog, racquetball, etc.)	0	1	2	3	N/A
33. Travel by bus, train, plane	0	1	2	3	N/A

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 3) _____

Total percentage score _____

VESTIBULAR REHABILITATION PROGRAM
SYMPTOM CHECKLIST

Name: _____
 Date: _____

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	<div style="border: 1px solid black; width: 150px; height: 20px; display: inline-block;"></div>			

Name _____
 Date _____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question as it pertains to your dizziness or unsteadiness only.

P1. Does looking up increase your problem?	Yes	Sometimes	No
E2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
F7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E9. Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
E10. Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
P13. Does turning over in bed increase your problem?	Yes	Sometimes	No
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15. Because of your problem, are you afraid people may think you're intoxicated?	Yes	Sometimes	No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	Yes	Sometimes	No
E20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22. Has your problem placed stress on your relationship with family members or friends?	Yes	Sometimes	No
E23. Because of your problem, are you depressed?	Yes	Sometimes	No
F24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P25. Does bending over increase your problem?	Yes	Sometimes	No

This section is to be filled out by Therapist

	(x 4)	(x0)	(x2)
Total:	_____	_____	_____
P = _____	_____	_____	_____
28%	E = _____	F = _____	_ 0 _
36%	36%		