Allens Creek Family Optometry PLLC

Allens Creek Family Optometry – Vestibular Symptom Inventory

Name:_____ DOB: _____ Date:_____

Symptoms began when?_____

Symptoms include what?

_____

_____

Have you had therapy of any kind? _____

If yes, what type, when, and where?

_____

_____

_____

Have you had any imaging (MRI, CT, etc.)? _____

Please rate the following symptoms (0 = never, 1 = seldom, 2 = often, 3 = always)

Pain

____ I am painfully sensitive to certain lights.
____ I am bothered by screens.
____ I get headaches.
____ I have neck (or other body) pain.

Emotions

____ I get easily overwhelmed.
____ I get anxious.
____ I have moderate/extreme mood swings.

Balance

____ I have poor balance.
____ I get dizzy.
____ I get nauseous or have motion/car sickness.

Hearing

____ Ringing in ears (tinnitus)
____ Ear infections
____ Loss of hearing

Eye

____ I see double.
____ Things look blurry.
____ Looking at things makes me tired or causes me pain.

Body

____ I am clumsy.
____ I avoid certain activities that I used to do with ease.

Thinking

____ I have trouble paying attention.
____ I have trouble reading and comprehending.
____ I have difficulty remembering.