PALMER PHYSICAL THERAPY for WOMEN

10333 E. 21st Street N. Suite 406 Wichita, KS 67206 316.630.9944

VESTIBULAR HISTORY FORM

Date: _____/_____ /_____

Name: _____ Age: _____ Height: _____ Weight: _____

Current Symptoms: Check all that apply.
**(In the space after each symptom, rate the severity of that symptom on a scale of 0-10, with 10 being most severe).

☐ Dizziness	☐ Visual Changes	☐ Brain Fog	☐ Tingling in Hands/Feet
☐ Spinning	☐ Hearing Loss	☐ Unsteadiness	☐ Double Vision
☐ Falling	☐ Lightheadedness	☐ Rocking/Tilting	☐ Fainting
☐ Headache	☐ Noise in Ears	☐ Fullness, Pressure, Pain in Ears	☐ Nausea/Vomiting
☐ Fatigue	☐ Other: _____		

When did your problem(s) start (date)? _____
Was it associated with an event (e.g. accident, head injury)? ☐ Yes ☐ No; if yes, please explain: _____
_____
Was the onset of your symptoms: ☐ Sudden ☐ Gradual ☐ Overnight ☐ other
Describe: _____

Are your symptoms: ☐ Constant ☐ Variable
If variable: How long do spells last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days;
How often do to the spells occur? _____
Do you have any warning signs that a spell is about to happen? ☐ Yes ☐ No; if yes, please explain: _____
Are you completely free of symptoms between spells? ☐ Yes ☐ No; if no, please explain: _____

Do your symptoms occur with changing positions? ☐ Yes ☐ No; if yes, check all that apply:

☐ Rolling your body to the left	☐ Rolling your body to the right
☐ Moving from lying to a sitting position	☐ Looking up with your head back
☐ Turning head side to side while sitting/standing	☐ Bending over with your head down

Is there anything that makes your symptoms better? ☐ Yes ☐ No; if yes, please explain: _____
_____

Is there anything that makes your symptoms worse? ☐ Yes ☐ No; if yes, check all that apply:

☐ Moving my head	☐ Time of day	☐ Riding/driving in the car
☐ Loud sounds	☐ Eating certain foods	☐ Large crowds/busy environment
☐ Standing up	☐ Menstrual periods	☐ Coughing/blowing nose/sneezing/straining
☐ Stress	☐ Physical activity/exercise	☐ Other: _____

When you have symptoms, do you need to support yourself to stand or walk? ☐ Yes ☐ No
When you are walking, do you: ☐ Veer left ☐ Veer right ☐ Remain in a straight path?
Have you ever fallen because of this problem? ☐ Yes ☐ No

Do you have a history of:

☐ Migraines	☐ Seizures	☐ Tumor	☐ Stroke
☐ Multiple Sclerosis	☐ Neuropathy	☐ Panic Attacks/Anxiety	☐ Congestive Heart Failure
☐ Concussion	☐ Depression	☐ Cervical Spine Arthritis	☐ Ataxia
☐ Glaucoma	☐ Macular Degeneration	☐ Parkinson's Disease	☐ Diabetes Mellitus

Has there been a recent change in your vision, including contacts or glasses? ☐ Yes ☐ No; if yes, please explain:
_____

Do you have difficulty hearing? ☐ Yes ☐ No
If yes, which ear(s): ☐ Left ☐ Right ☐ Both; When did this start? _____
Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ☐ Yes ☐ No

Have you seen other healthcare providers for your current condition/symptoms? ☐ Yes ☐ No ; if yes, please explain:
_____
_____