coastal physiotherapy

and sports rehabilitation

VESTIBULAR ASSESSMENT **Date**: _____

Name: _____ **Age**: _____

Family/Referring Physician: _____

Describe the major problem or reason you are seeing us: _____
When did the problem begin: _____

Specifically, do you experience spells of vertigo (a sense of spinning)? **YES** **NO**
If **YES**, how long do these spells last? _____

When was the last time the vertigo occurred? _____
*Is the vertigo:

Spontaneous	YES	NO
Induced by motion	YES	NO
Induced by position changes	YES	NO

Do you experience a sense of being off-balance (disequilibrium)? **YES** **NO**
* If **YES**, is the feeling of being off-balance:

Constant	YES	NO	Worse with fatigue	YES	NO
Spontaneous	YES	NO	Worse outside	YES	NO
Induced by motion	YES	NO	Worse in the dark	YES	NO
Induced by position changes	YES	NO			

Does the feeling of being off-balance occur when:

Lying down	YES	NO	Sitting	YES	NO
Standing	YES	NO	Walking	YES	NO

Do you OR have you fallen (to the ground) **YES** **NO**
If **YES**, how often do you fall? _____

Have you injured yourself? _____

Do you stumble, stagger, or side-step while walking **YES** **NO**

Do you drift to one side while walking? **YES** **NO**
If **YES**, to which side do you drift? Right Left

Past Medical History

Do you have:	Diabetes	Yes	No	Headaches	Yes	No
	Hypertension	Yes	No	Back Problems	Yes	No
	Arthritis	Yes	No	Neck Problems	Yes	No
	Heart disease	Yes	No	Pulmonary Problems	Yes	No
	Hearing Problems	Yes	No	Other: _____		

What Medications are you taking: _____