sense of balance
physiotherapy and vestibular rehabilitation

Suzanne Douglas
B App. Sci, (Physio) MAPA; Grad Dip Health Ed.

Patient Questionnaire

Please answer all the questions to the best of your ability.
Bring this questionnaire with you to your consultation*....do not mail it back.*
Your answers allow us to devote more time to ***your specific problem*** *during your consultation.*

Name: _____ **Date**: ___/___/____

Phone: _____ **Date of Birth**: ___/___/____

Address: _____

Name of GP/Specialist: _____

GP/Specialist Contact Details: _____

Describe your major problem or the reason you are seeing us: _____

_____

_____

Date the problem started: ___/___/____

Circumstances *(what happened at the time?):* _____

_____

_____

What were your initial symptoms? _____

If you have episodes (or spells) describe in detail a typical episode, including how often they occur and how long they last: _____

_____

_____

Any previous treatment? _____

Have you had any investigations into your problem?	yes	when	result
Hearing tests			
Evaluation by a neurologist			
Evaluation by an ENT doctor			
Caloric tests (water or air in the ear)			
XRay ,CT or MRI			

What do YOU personally think your problem is due to?

_____

Present occupation: _____

Hobbies: _____

How much exercise do you do each week? _____

Are you able to drive at the moment? _____

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In the last 6 months, how much of your time has dizziness interfered with your activities?
(mark the line)

|----------|----------|----------|----------|----------|
0% 20% 40% 60% 80% 100%

Symptoms: Please rate your symptoms (**0**) none, (**1**) mild, (**2**) moderate, or (**3**) severe.

Trouble walking		Poor balance		Falls	
Spinning, tumbling or turning		Pushing or pulling		Tilting	
Light-headedness, or fainting feeling		Spinning inside your head		Sweating	
Fear of being in public places		Floating		Swimming	
Nausea/ Queasiness		Giddiness		Vomiting	
Rocking		Double vision		Blurred vision	
Flashes of light		Jumping of vision when walking, or in car			

If you experience dizziness or vertigo, to what extent is it brought on by…….

Tick one answer per question

	None	Some	Severely
Turning over in bed or bending over			
Looking up			
Standing up			
Rapid head movements			
Walking in a dark room			
Walking on uneven surfaces			
Loud noises			
Cough, strain, sneeze, laugh			
Movements of objects around you			
Moving your eyes while your head is still			
Wide open spaces			
Tunnels, bridges, supermarkets			
Menstrual periods			
Time of the day			

Can you bring on your symptoms voluntarily? ☐No ☐Yes
If yes, how?_____

Do you have moderate /severe motion sickness? ☐No ☐Yes
If yes, when did it start?_____

Do you avoid situations in which you are tumbled or spun? ☐No ☐Yes
(amusement rides, swings etc) If yes, from when?_____

Has anyone noticed your eyes jerking when you have dizzy spells? ☐No ☐Yes

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Hearing. Have you ever had?	**No**	**Yes**
Infections of your ears		
Difficulty with your hearing		
Pain, fullness, popping or pressure in your ear		
Pain, pins and needles, numbness, or weakness in your face		
Crossed eyes or lazy eye		
Tinnitus (ringing, humming, whistling)		

If you answered yes to **Tinnitus,** please answer the following questions:

How often and for how long have you had tinnitus in the past 6 months?

_____

Which ear, or both? _____

Steady or pulsating? _____

High or low pitched? _____

Review of other systems: **In the past 6 months have you noticed……**	**No**	**Yes**	*Details*
Significant loss of strength			
Significant loss of energy			
More than 5 kg weight loss (unintentional)			
Significant memory loss			
Change in your hand writing			
Pins and needles or numbness			
Muscle or joint aches or pains			
Leaking of urine			
Problems sleeping			
Shortness of breath			
Trouble chewing, swallowing or speaking			
Incoordination			
Irregular or fast beating of your heart			
Headaches			

If you answered yes to **Headaches,** please answer the following questions*:*

When did they begin? _____

How often do you get them? _____

Rate your pain intensity from 1 to 10 *(10 is most severe)* _____

Have you had at least 5 headaches that:	**No**	**Yes**
Lasted at least 4 hours		
Started on one side of your head		
Were throbbing		
Were severe enough to interfere with your schedule		
Were associated with vomiting or nausea		
Were aggravated by bright lights or loud noises		

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Past medical history:

Have you had any injuries due to trauma? ☐No ☐Yes

If yes, please describe_____

Have you had any surgery? ☐No ☐Yes

If yes, please describe_____

Have you been exposed to any of the following?	No	Yes
Intravenous or high dose, extensive antibiotics		
Drug therapy for cancer		
Loud noises (guns, machinery, very loud music)		

Has your health been affected by?	No	Yes	*Details*
Heart problems			
Diabetes			
Thyroid disorders			
Depression, anxiety, severe stress, phobias			
High cholesterol			
High or low blood pressure			
Pain in the back of jaw, or tooth grinding			
Loss of consciousness (faints)			
Seizures or convulsions			
Arthritis			
Neck pain			
Other condition			

If you use alcohol, how much?_____

Do you have a history of smoking? ☐No ☐Yes…..how much?_____

How many cups of tea, coffee, soda or coke do you drink each day?_____

Family history: Have any of your family had?	Mother	Father	Children
Severe headaches			
Meniere's disease/syndrome			
Hearing loss			
Vertigo or dizziness			
Balance problems or a tremor			
Diabetes			
Stroke, or other neurological conditions			
Cancer or brain tumours			
Heart disease			
High blood pressure			
Psychiatric problems			

Are you allergic to any medications or other substances? ☐No ☐Yes

If yes, please describe_____

Current medications (please list.):_____

Continue overleaf…….

Thank you. .Please remember to bring this questionnaire with you to your consultation