

1. Please describe the MAJOR problem or reason you are seeing us here today:

2. Please describe, in detail, the circumstances (and date if possible) when your problem began:

3. Please rate, on a scale of 1 (little problem) to 10 (worst possible) how limiting this problem is:

Today: ___/10

At worst ___/10

4. Are the symptoms constant (Y /N) or do they come in spells (Y /N)? If you have spells, please describe a typical spell in as much detail as possible (quality, frequency, duration and triggers)?

5. Please characterize your problem:

| | |
|---|---|
| <input type="radio"/> Sense of spinning | <input type="radio"/> Impaired vision |
| <input type="radio"/> Lightheaded/ swimming | <input type="radio"/> Provoked by loud or specific sounds |
| <input type="radio"/> Trouble walking | <input type="radio"/> Provoked by pressure changes |
| <input type="radio"/> Sensation of imbalance/ tilting | <input type="radio"/> Provoked by position changes If so, describe |

6. Check any associated symptoms or other sensations which accompany your specific problem:

| | |
|---|--|
| <input type="radio"/> Black out or fainting when dizzy | <input type="radio"/> Difficulty swallowing |
| <input type="radio"/> Headaches | <input type="radio"/> Tingling around mouth |
| <input type="radio"/> Double or blurry vision | <input type="radio"/> Spots before eyes |
| <input type="radio"/> Numbness in face or extremities | <input type="radio"/> Jerking of arms and legs |
| <input type="radio"/> Weakness or clumsiness arms/ legs | <input type="radio"/> Confusion or memory loss |
| <input type="radio"/> Slurred or difficult speech | <input type="radio"/> Change in hearing |

7. Check any triggers that may be linked with your specific problem

| | |
|---|---|
| <input type="radio"/> Stress | <input type="radio"/> Straining/ lifting |
| <input type="radio"/> Menstrual period | <input type="radio"/> Preceded by cold or flue |
| <input type="radio"/> Overwork or exertion | <input type="radio"/> Recent change in eyeglasses |
| <input type="radio"/> Noted minutes to hours after eating | <input type="radio"/> Diet |

| | |
|---|-----------------------------------|
| <input type="radio"/> Noted after urinating | <input type="radio"/> Loud noises |
|---|-----------------------------------|

8. Do you have a history of motion sickness (Y/ N)? ___All my life ___Recently only

9. What medical procedures have been done previously to investigate or treat this problem (hearing tests, head scans, blood work, ect)?

10. Do you have anything else to tell about your problem that has not already been asked by this questionnaire? _____

11. How have you tried to treat this problem?

12. What is your goal for being here today?
