BRENTWOOD PHYSIOTHERAPY AND MASSAGE
PENINSULA PHYSIOTHERAPY AND MASSAGE

VESTIBULAR ASSESSMENT - PART 1 (PATIENT)

Date: _____
Patient Name: _____
Age: _____ **Occupation:** _____
Family/Referring Physician: _____
CT Scan: __ YES or __ NO

Describe the major problem or reason for this appointment: _____
_____
_____

When did this problem begin? _____
_____

Specifically, do you experience spells of vertigo (a sense of spinning)? __YES or __NO
If YES, how long do these spells last?_____
When was the last time the vertigo occurred? _____
Is the Vertigo; *(please check off applicable)*

__ Spontaneous __ Induced by motion __ Induced by position changes

Do you experience a sense of being off-balance (disequilibruim)? __ YES or __ NO

If YES, is the feeling of being off-balance; *(please check off applicable)*
__ Constant __ Spontaneous __ Induced by motion
__ Induced by position changes __ Worse with fatigue __ Worse outside

Does the feeling of being off balance occur when; *(please check off applicable)*
__ Lying Down __ Standing __ Sitting __ Walking

Do you, OR have you fallen (to the ground)? __ YES or __ NO

If yes, please describe; _____
_____
How often do you fall? _____
Have you injured yourself? (if yes, please describe) _____
_____

Do you stumble, stagger, or side-step while walking? __ YES or __NO

Do you drift to one side while you walk? __ YES or __ NO
If YES, to which side do you drift? __ Right or __ Left

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Past Medical History

(please check applicable)

Do you have;
__Diabetes __Heart Disease __Hypertension
__ Arthritis __Headaches __Back Problems
__Neck Problems __Hearing Problems __Visual Problems
__Pulmonary Problems

Have you been in an accident? __ YES or __ NO If yes, when did it occur?_____

What medications are you taking? _____
_____

Social History

Do you live alone? __ YES or __NO If NO, who lives with you? _____
Do you have stairs in your house? __ YES or __NO If YES, how many? _____
Do you smoke? __ YES or __ NO If YES, how much per day? _____
Do you drink alcohol? __ YES or __ NO IF YES, how much? _____
Do you have trouble sleeping? __ YES or __ NO

Functional Status

Are in independent in self-care activities? __ YES or __ NO

Can you drive;
In the daytime? __ YES or __ NO In the Nighttime? __ YES or __ NO

Are you working? __ YES or __ NO

Are you on Medical Disability? __ YES or __ NO

Are you able to: (*Please check applicable)*
__ Watch TV __ Read __ Go Shopping __ Be in Traffic

Initial Visit

(for the following, please pick the one statement that best describes how you feel)

___ Negligible symptoms
___ Bothersome symptoms
___ Performs usual work duties but symptoms interfere with outside activities
___ Symptoms disrupt performance of both usual work duties and outside activities
___ Currently on medical leave or had to change jobs because of symptoms
___ Unable to work for over one year or established permanent disability with compensation payments