



Physical Therapy  
Occupational Therapy  
Speech Pathology

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**VESTIBULAR / BALANCE HISTORY FORM**

**NAME:**

**DATE OF BIRTH:**

**PLEASE DESCRIBE YOUR FIRST EPISODE OF DIZZINESS OR IMBALANCE INCLUDING THE DATE AND INITIAL SYMPTOMS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE DESCRIBE A TYPICAL SPELL IN AS MUCH DETAIL AS POSSIBLE INCLUDING HOW OFTEN THEY OCCUR AND HOW LONG THEY USUALLY LAST:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DO YOU FEEL YOUR SYMPTOMS ARE (CHOOSE ONE):**

\_\_\_\_ BECOMING WORSE    \_\_\_\_ STAYING THE SAME    \_\_\_\_ IMPROVING

**CHECK ALL THAT APPLY TO YOU CURRENTLY:**

- |                                         |                                       |                                                            |
|-----------------------------------------|---------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> POOR BALANCE   | <input type="checkbox"/> SPINNING     | <input type="checkbox"/> SPINNING INSIDE HEAD              |
| <input type="checkbox"/> PULLING        | <input type="checkbox"/> TILTING      | <input type="checkbox"/> FULLNESS OR PRESSURE IN EARS      |
| <input type="checkbox"/> FALLS          | <input type="checkbox"/> FLOATING     | <input type="checkbox"/> RINGING IN EARS                   |
| <input type="checkbox"/> ANXIETY        | <input type="checkbox"/> ROCKING      | <input type="checkbox"/> TROUBLE WITH SPEECH OR SWALLOWING |
| <input type="checkbox"/> NAUSEA         | <input type="checkbox"/> VOMITING     | <input type="checkbox"/> NUMBNESS OR TWITCHING             |
| <input type="checkbox"/> HEADACHES      | <input type="checkbox"/> NECK PAIN    | <input type="checkbox"/> FLASHES OF LIGHT                  |
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> LIGHT HEADED |                                                            |

**IF YOU ANSWERED YES TO HEADACHES, PLEASE ANSWER THE FOLLOWING:**

AGE THEY BEGAN \_\_\_\_\_

NUMBER PER MONTH \_\_\_\_\_

PAIN INTENSITY (0 - 10, 10 BEING WORST) \_\_\_\_\_

DO THEY LAST AT LEAST 4 HOURS? \_\_\_\_\_

ARE THEY AGGRAVATED BY LIGHT OR NOISE? \_\_\_\_\_

DO THEY INTERFERE WITH YOUR DAILY ROUTINE? \_\_\_\_\_

ARE THEY THROBBING OR PULSE LIKE? \_\_\_\_\_

ARE THEY ASSOCIATE WITH NAUSEA AND/OR VOMITING? \_\_\_\_\_

HAVE YOU HAD:	YES OR NO	WHEN	RESULTS
HEARING TEST	YES NO		
EVALUATION BY NEUROLOGIST	YES NO		
EVALUATION BY EYE DOCTOR	YES NO		
EVALUATION BY EAR DOCTOR	YES NO		
MRI	YES NO		
CALORIC TEST (WATER OR AIR IN EAR)	YES NO		

PLEASE LIST ANY PRIOR MEDICAL HISTORY:

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PLEASE LIST ALL CURRENT MEDICATIONS:

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PLEASE LIST OTHER TREATMENTS YOU HAVE TRIED PREVIOUSLY:

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CHECK ALL THAT APPLY TO YOUR DAILY ACTIVITIES:

- |                                                                       |                                                                   |
|-----------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> TWO OR MORE FALLS IN THE PAST YEAR           | <input type="checkbox"/> ANY FALL WITH AN INJURY IN THE PAST YEAR |
| <input type="checkbox"/> DIFFICULTY WALKING ON UNEVEN GROUND          | <input type="checkbox"/> DIFFICULTY IN BUSY PLACES SUCH AS STORES |
| <input type="checkbox"/> DIFFICULTY WALKING IN THE DARK               | <input type="checkbox"/> DIFFICULTY WATCHING TV OR USING COMPUTER |
| <input type="checkbox"/> DIFFICULTY MOVING QUICKLY                    | <input type="checkbox"/> SYMPTOMS WHILE DRIVING OR CANNOT DRIVE   |
| <input type="checkbox"/> FEAR OF FALLING                              |                                                                   |
| <input type="checkbox"/> WALK TOUCHING WALLS OR FURNITURE FOR BALANCE |                                                                   |

PLEASE LIST ANY HOUSEHOLD, WORK OR RECREATIONAL ACTIVITIES YOU ARE UNABLE TO DO DUE TO YOUR SYMPTOMS:

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THERAPIST COMMENTS:

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