koru chiropractic
WELLNESS CENTRE

Patient Name: _____ Date: _____

Vestibular Health History Form:

Please answer the following questions as best as you can as they relate to you:

1. Please describe below your complaint in your own words without using the word dizzy:

_____

_____

_____

2. How would you describe your complaint (check all that apply): ☐ Dizziness ☐ Vertigo ☐ Unsteadiness ☐ Giddiness ☐ Lightheadedness ☐ Other: _____

3. Have you seen anyone else for this present complaint? ☐ No. ☐ Yes. If yes, please complete:

Who have you seen: _____

What treatments have you received: _____

What were the outcomes: _____

4. Have you ever experienced this type of problem before? ☐ No. ☐ Yes. If yes, please complete:

When & how many times did you have these dizzy spells? _____

Did you see anyone for your past dizziness? _____

What treatments did you receive? _____

What were the outcomes? _____

5. Do you ever have any of the following sensations:

Spinning in circles? ☐ No. ☐ Yes, describe the direction: _____

Falling to one side? ☐ No. ☐ Yes, describe the direction: _____

The world is spinning around you? ☐ No. ☐ Yes, describe the direction: _____

You are spinning around the world? ☐ No. ☐ Yes, describe the direction: _____

6. Because of this present problem, have you had any falls? ☐ No. ☐ Yes.

Have you injured yourself from falling? ☐ No. ☐ Yes, explain: _____

7. The following questions refer to a typical "dizzy spell."

When did you notice your first dizzy spell? (i.e. date) _____

Please describe in your own words where you were & how your first dizzy spell came on: _____

_____

Were you taking any medication, over the counter or prescribed, at the times that these symptoms began? ☐ No. ☐ Yes.

If yes, describe: _____

Does anything trigger the onset of your dizzy spells? ☐ No. ☐ Yes. If yes, describe: _____

_____

Did you have a recent cold or flu prior to your dizzy spells? ☐ No. ☐ Yes.

Do these dizzy spells come in attacks? ☐ No. ☐ Yes.

How often do these dizzy spells occur? _____

How long do these dizzy spells last? _____

What time of day do these dizzy spells occur? _____

Are you completely free of your dizziness between attacks? ☐ No. ☐ Yes.

Does your dizziness occur mainly when you sit-up or stand-up quickly? ☐ No. ☐ Yes.

Are there certain positions that you are mainly dizzy in? ☐ No. Yes. If yes, describe: _____

_____

Are you dizzy even when lying down? ☐ No. ☐ Yes.

Do you have difficulty getting into bed? ☐ No. ☐ Yes.

Doctor's Notes: _____

_____

_____

7. **The following questions refer to a typical "dizzy spell."** ***(Continued)***

Does rolling over in bed worsen your present problem? ☐ No. ☐ Yes.
Do fast head movements increase your present problem? ☐ No. ☐ Yes.
Do you have difficulty reading? ☐ No. ☐ Yes.
Does looking up make your dizzy spells worse? ☐ No. ☐ Yes.
Does walking down the isle of a supermarket make your problem worse? ☐ No. ☐ Yes.
Do you have trouble walking in the dark? ☐ No. ☐ Yes.
Are the dizzy spells better when you lie or sit perfectly still? ☐ No. ☐ Yes.
Does anything ***alleviate*** your dizzy spells? ☐ No. ☐ Yes, please explain: _____

_____

Does anything make them ***worse***? ☐ No. ☐ Yes, please explain: _____

_____

8. **The next questions relate to other sensations or symptoms you may have.**

Do you also get nauseated when having a dizzy spell? ☐ No. ☐ Yes.
Do you ever black out or faint with your dizzy spells? ☐ No. ☐ Yes.
Do you experience fullness, pressure, or ringing in your rears? ☐ No. ☐ Yes, when: _____
Have you experienced pain or discharge from your ears? ☐ No. ☐ Yes, when: _____
Have you had any hearing loss? ☐ No. ☐ Yes.
Have you had severe or recurrent headaches? ☐ No. ☐ Yes.
Have you noticed any visual problems such as blurry or double vision? ☐ No. ☐ Yes.
Have you noticed any of the following: ☐ Clumsiness ☐ Uncoordinated movement
☐ Trouble with smooth movement of arms. ☐ Trouble with smooth movement of legs. ☐ None of these
Do you stumble, stagger, or side-step when walking? ☐ No. ☐ Yes.
Do you drift to one-side when you walk? ☐ No. ☐ Yes, which side: _____
Are you having any problems with concentration or memory loss? ☐ No. ☐ Yes.
Have you had any recent head trauma? ☐ No. ☐ Yes, please explain: _____

_____

Did you experience any trauma around or before the time that your dizzy spells began? ☐ No. ☐ Yes, please explain:

_____

9. **These questions relate to how your dizziness or unsteadiness relates to your daily life:**

Does this problem make you frustrated? ☐ Somewhat frustrated ☐ Moderately frustrated ☐ Extremely frustrated
Does this problem restrict your travel? ☐ No. ☐ Yes.
Does it embarrass you in front of others? ☐ No. ☐ Yes.
Are your symptoms affecting your social activity? ☐ No. ☐ Yes.
Do you have to avoid heights? ☐ No. ☐ Yes.
Are you afraid people might think you are intoxicated or drunk? ☐ No. ☐ Yes.
Are you able to act independently in self care activities (e.g hygiene)? ☐ No. ☐ Yes.
Is this problem affecting your ability to work? ☐ No. ☐ Yes, how so: _____

10. **What do you think is the reason you are having these dizzy spells?** _____

Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by Doctor Stefan Billing at Koru Chiropractic and Functional Neurology. Any disclosure is outlined in our privacy policies.

Patient's signature (*or guardian's signature*): _____ Date: _____

_____ Signature of translator or person assisting with this form (*if any*)

Printed name of said person: _____ Date: _____

Doctor's Notes: _____

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