

Patient Diagnostic Intake Form

Patient Name: _____ Date of Birth: _____ Sex: _____

Provider Name: _____ Appointment Date: _____

CURRENT SYMPTOMS

Which of the following **best describes your symptoms?**

- Imbalance You feel as if you are spinning; the world is not spinning
 Falling more often Lightheadedness
 Nausea Other: _____
 The world is spinning around you

How long do your symptoms last **without stopping?**

- Seconds Minutes Hours Days Constant

Check one: How many times per day week month year do you have an episode? _____

Did any of the following occur **immediately before your symptom onset?** (*Check all that apply*)

- Head trauma A virus or infection (e.g., shingles, cold sores, Covid-19)
 Motor vehicle accident Surgery
 Upper respiratory infection Stressful event or high stress
 Change in medication Other: _____
 A fall

Check one: Have your symptoms improved changed stayed the same since they began?

If improved or changed, how so? _____

Does anything make your symptoms better? _____

BALANCE AND FALL SYMPTOMS

Have you fallen in the past year? Yes No

If yes, how many times? _____

If no, have you experienced “near falls” but you caught yourself? Yes No

Are you afraid of falling? Yes No

Are you veering/leaning while walking? Yes No

If yes, which direction? Left Right Both

Do you have neuropathy, numbness or tingling in your feet or legs? Yes No

Has your exercise decreased? Yes No

If yes, approximately when? _____

Orthopedic injuries/issues? Yes No

If yes, please explain: _____

DIZZINESS SYMPTOMS

Do you have a history of migraines? Yes No

If yes, when was your most recent migraine? _____

Do any of the following trigger your symptoms? *(Check all that apply)*

Increased stress

Changes in weather

Skipping a meal

Certain foods: _____

Not drinking enough water

Do any of the following **accompany** or occur **immediately prior** to an episode of your symptoms?
(Check all that apply)

Headaches

Hearing changes: Left Right Both

Neck pain

Fullness in your ear(s): Left Right Both

Nausea/Vomiting

Ringing in your ear(s): Left Right Both

Shimmers, sparkles or
flashing lights in your vision

Sensitivity to: *(Check all that apply)*
 Light Sound Smell Patterns Screens Motion

My dizziness is intense but only lasts for seconds or minutes. Yes No

I get dizzy when I turn over in bed. Yes No

I get short-lasting, spinning dizziness when I bend down to pick something up. Yes No

I get short-lasting, spinning dizziness that happens when I go from sitting to lying down. Yes No

I can trigger my dizzy spells by placing my head in certain positions. Yes No

I have had a single severe spell of spinning dizziness that lasted for hours to a day. Yes No

After my big episode of dizziness, I could not walk for days without falling over. Yes No

I had a spell of spinning dizziness that lasted for hours after I had a cold, virus or flu. Yes No

I had hearing loss in one ear at the same time I had the long episode of spinning dizziness. Yes No

I have spells where I get dizzy, and it is difficult for me to breathe. Yes No

I feel dizzy all the time. Yes No

I am anxious most of the time. Yes No

I am bothered by patterns, screens, e.g., supermarkets. Yes No

My symptoms increase when I go from lying to sitting or sitting to standing. Yes No

When I sit up from lying down or stand up from sitting, I experience a few seconds of dizziness.
 Yes No

When I cough or sneeze, I get dizzy. Yes No

I get dizzy when I strain to lift something heavy. Yes No

When I speak, my voice sounds abnormally loud to me. Yes No

My dizziness is provoked by head movements (e.g., up/down and/or right/left). Yes No

My head is heavy like a bowling ball. Yes No

I have a headache that is in or starts in the back of my head. Yes No

DIZZINESS SYMPTOMS

Anxiety/stress

Thyroid dysfunction

Low blood pressure

Depression

Diabetes

Ménière's disease

Motion sickness

High blood sugar

Date of diagnosis: _____

Cardiac problems

Low blood sugar

Stroke/TIA

Respiratory problems

High blood pressure

Eye/vision concerns

HEARING HEALTH SYMPTOMS

Do you have hearing loss? Yes No

If yes, which ear? Left Right Both

If yes, was it sudden? Yes No

Do you wear hearing aids? Yes No

I am experiencing ear: Pain Ringing Drainage Fullness

If yes, which ear? Left Right Both

Have you had ear surgery? Yes No

If yes, which ear? Left Right Both

Acoustic neuroma Mastoid Cochlear implant Other: _____

IF APPLICABLE: FEMALE HORMONAL HISTORY

Are you pre peri post menopausal?

Have you ever had a hysterectomy? Yes No

If yes, when? _____

Have you had any changes to your contraceptives? Yes No

If yes, when? _____

Do you have known hormonal imbalance? Yes No

If yes, are you being treated for the issue? Yes No