BALANCE/VESTIBULAR INTAKE FORM

Hudson Valley AUDIOLOGY CENTER

Primary Concern/Reason for visit:

Symptom Description (circle all that apply):

Light Headedness	Difficulty with Memory	Ear fullness/ pressure
Visual Disturbances	Ringing in ears	Passing out/ fainting
Disorientation	Nausea	Balance Difficulty
Hearing loss	Spinning	Fatigue/ weakness
Headaches Rocking/ Swaying	Facial Numbness	Other: _____

How often do symptoms occur (circle)?

Daily	Weekly	Constantly

How long do symptoms last?

Seconds/Minutes	Hour/Hours	Days/Months

Symptoms increase with (circle all that apply):

Rolling in bed	Looking up/down	Bending/ Squatting
Turning head	Crowds	Driving
Walking	Loud Noises	Cough/ Sneeze
Reading	Standing up/lying down	Other: _____

Medical History (circle all that apply):

Osteoporosis	Arthritis Numbness/Tingling	Shortness of Breath
Previous Therapy	Asthma	Depression
Seizure/ Epilepsy	Diabetes 1	Diabetes 2
Anemia	Anxiety	Thyroid Problems
Cardiovascular Disease	Head Injury/ Concussion	Other: _____

Have you fallen in the past 6 months? (if yes, please describe below):

Surgical history (type/date)**/ Previous Imaging** (X-Ray, MRI, EMG, CT scan etc.)**:**

Current Medications (prescription, non-prescription, recreational drugs, vitamins, OTC, herbals, etc.)**:**

DIZZINESS HANDICAP INVENTORY

Hudson Valley AUDIOLOGY CENTER

Name:_____DOB:_____Date:_____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question. *Answer each question as it applies to your dizziness or unsteadiness only.*

ITEM	QUESTION	Y	N	S
1 – p	Does looking up increase your problem?			
2 – e	Because of your problem, do you feel frustrated?			
3 – f	Because of your problem, do you restrict your travel for business of recreation?			
4 – p	Does walking down the aisle of a supermarket increase your problem?			
5 – f	Because of your problem, do you have difficulty getting into or out of bed?			
6 – f	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or parties?			
7 – f	Because of your problem, do you have difficulty reading?			
8 – p	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?			
9 – e	Because of your problem, are you afraid to leave your home without having someone accompany you?			
10 – e	Because of your problem, are you embarrassed in front of others?			
11 – p	Do quick movements of your head increase your problems?			
12 – f	Because of your problem, do you avoid heights?			
13 – p	Does turning over in bed increase your problem?			
14 – f	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
15 – e	Because of your problem, are you afraid people may think you are intoxicated?			
16 – f	Because of your problem, is it difficult for you to walk by yourself?			
17 – p	Does walking down a sidewalk increase your problem?			
18 – e	Because of your problem, is it difficult for you to concentrate?			
19 – f	Because of your problem, is it difficult for you to walk around the house in the dark?			
20 – e	Because of your problem, are you afraid to stay home alone?			
21 – e	Because of your problem, do you feel handicapped?			
22 – e	Has your problem placed stress on your relationship with members of your family or friends?			
23 – e	Because of your problem, are you depressed?			
24 – f	Does your problem interfere with your job or household responsibilities?			
25 – p	Does bending over increase your problem?			
		x 4	**x 0**	**x 2**
	=			
	TOTAL			

P_____ E_____ F_____

- 100-70; severe perception of having handicap
- 69-40; moderate perception of handicap
- 39-0; low percentage of handicap

Notes: