Alton PHYSIOTHERAPY & SPORTS CLINIC
4040 Palladium Way, Unit 5. Burlington, ON L7M 0V6
Tel: (905) 335-6100 Fax: (905) 335-6160

VESTIBULAR ASSESSMENT - PART 1

Name: _____ Date: _____

Birthdate: _____ Age: _____ Occupation: _____
DD / MMM / YYYY

Family/Referring Physician: _____

Describe the major problem or reason you are seeing us: _____

_____

When did the problem begin: _____

Specifically, do you experience spells of vertigo (a sense of spinning)? ☐ YES ☐ NO

If YES, how long do these spells last? _____

When was the last time the vertigo occurred? _____

Is the vertigo:

spontaneous ☐ YES ☐ NO
induced by motion ☐ YES ☐ NO
induced by position changes ☐ YES ☐ NO

Do you experience a sense of being off-balance (disequilibrium)? ☐ YES ☐ NO

If YES, is the feeling of being off-balance:

Constant?	☐ YES	☐ NO			
Spontaneous?	☐ YES	☐ NO			
Induced by motion?	☐ YES	☐ NO	Worse in the dark?	☐ YES	☐ NO
Induced by position changes?	☐ YES	☐ NO	Worse outside?	☐ YES	☐ NO
Worse with fatigue?	☐ YES	☐ NO	Worse on uneven surfaces?	☐ YES	☐ NO

Does the feeling of being off-balance occur when:

lying down	☐ YES	☐ NO	sitting	☐ YES	☐ NO
standing	☐ YES	☐ NO	walking	☐ YES	☐ NO

Do you OR have you fallen (to the ground)? ☐ YES ☐ NO

If yes, please describe?
How often do you fall?
Have you injured yourself?

Do you stumble, stagger, or side-step while walking? ☐ YES ☐ NO
Do you drift to one side while you walk? ☐ YES ☐ NO
If YES, to which side do you drift? ☐ Right ☐ Left

Past Medical History

Do you have:

Diabetes	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO
Hypertension	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Neck Problems	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO	Pulmonary Problems	☐ YES	☐ NO
Visual Problems	☐ YES	☐ NO	Hearing Problems	☐ YES	☐ NO

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Have you been in an accident? ☐ YES ☐ NO

If YES, when did it occur? _____

If YES, please describe _____

_____

What Medications are you taking? _____

_____

Social History

Do you live alone? ☐ YES ☐ NO

If NO, who lives with you? _____

Do you have stairs in your home? ☐ YES ☐ NO

If YES, how many? _____

Do you have trouble sleeping? ☐ YES ☐ NO

The scale below consists of a number of words that describe different feelings and emotions. Read each item and then indicate how you feel on the average using the numbers 1 2 3 4 5:
Mark the number in the space next to the word.

1 slightly/not at all	**2 A little**	**3 Moderately**	**4 Quite a bit**	**5 Extremely**
_____ Interested	_____ Irritable	_____ Jittery	_____ Strong	_____ Nervous
_____ Enthusiastic	_____ Distressed	_____ Alert	_____ Active	_____ Excited
_____ Ashamed	_____ Afraid	_____ Upset	_____ Inspired	_____ Hostile
_____ Guilty	_____ Determined	_____ Proud	_____ Scared	_____ Attentive

Functional Status

Are you independent in self-care activities? ☐ YES ☐ NO

Can you drive: In the daytime? ☐ YES ☐ NO In the night? ☐ YES ☐ NO

Are you working? ☐ YES ☐ NO

Are you on medical disability? ☐ YES ☐ NO

Are you able to:

Watch TV comfortably?	☐ YES	☐ NO	Read?	☐ YES	☐ NO
Go shopping?	☐ YES	☐ NO	Be in Traffic?	☐ YES	☐ NO
Work on a computer?	☐ YES	☐ NO	Be in a noisy place?	☐ YES	☐ NO

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