



Patient's Name _____

Today's Date ___/___/___

Balance/Dizziness Intake Addendum

Primary Concern:

History of falls? No ___ Yes ___ If yes how often? _____ When was last fall? _____

Describe the problem that brings you to therapy: _____

Date problem began: _____ Since then, has your problem:

Worsened ___ Improved ___ Same ___

Have you experienced a recent trauma? No ___ Yes ___ If yes describe _____

Have you ever experienced this problem before? No ___ Yes ___

If yes, please describe: _____

Symptoms:

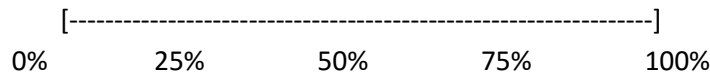
Symptom Description (circle all that apply):

- | | | | |
|-----------------------|---------------------|------------------------|------------------------|
| Light Headedness | Visual Disturbances | Disorientation | Hearing Loss |
| Headaches | Rocking/ Swaying | Difficulty with Memory | Ringing in Ears |
| Nausea | Spinning | Facial Numbness | Ear Fullness/ Pressure |
| Passing out/ Fainting | Balance Difficulty | Fatigue/ Weakness | Other: _____ |

How often do symptoms occur? Daily ___ Weekly ___ Constantly ___

How long do symptoms last? Seconds ___ Minutes ___ Hours ___ Days ___

In the last WEEK what percentage of the time has dizziness interfered with your activities? Mark on line below.



Symptoms increase with (circle all that apply):

- | | | | | |
|----------------|--------------------|---------|-------------------------|-------------|
| Rolling in Bed | Turn Head | Walking | Bearing down/ Straining | Reading |
| Lying to Sit | Look up/Down | Crowds | Lying Down | Loud Noises |
| Sit to Stand | Bending/ Squatting | Driving | Cough/ Sneeze | Other |