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.

[----------]

0% 25% 50% 75% 100%

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