TALLGRASS
BALANCE, HEARING &
PHYSICAL THERAPY, LLC

Vestibular Intake Form

Preferred Name:_____

Date of Birth:_____

How do you best describe your dizziness?

☐ Feeling of spinning ☐ Light-headed ☐ Woozy/ Off-Balance ☐ Other:_____

How long has the dizziness bothered you?

_____

Do certain positions seem to make the dizziness worse?

☐ Laying down ☐ Bending over ☐ Turning-Head ☐ Other:_____ ☐ No Noticeable Difference

Have you ever "blacked-out" or fainted when dizzy?

☐ Yes ☐ No ☐ Not sure

Do you experience any of the following when you get dizzy?

☐ Nausea ☐ Double Vision ☐ Tinnitus (ringing, buzzing, chirping, roaring) in your ears

☐ Vomiting ☐ Speech Difficulties ☐ Sudden or changing hearing loss

☐ Blurry Vision ☐ Head-Aches/Migraines ☐ Ears feeling full, plugged or painful

Have you had any changes to medications recently?

☐ Yes:_____ ☐ No

Have you been using any medications to help with the dizziness?

☐ Yes:_____ ☐ No

Do you have a history of ear infections or medical/ surgical treatments on your head, neck ears or throat?

☐ Yes ☐ No

When you get dizzy, about how long does it last?

☐ A few minutes ☐ 10-30 minutes ☐ 1-5 hours ☐ All day ☐ Several Days ☐ Other:_____

Do you have a history of any of the following surgeries?

Right ☐ Hip ☐ Knee

Left ☐ Hip ☐ Knee

Do you have a diagnosed hearing loss?

☐ Yes ☐ No

Do you wear hearing aids?

☐ Yes ☐ No

Have you had any falls in the past year? If yes, how many?

☐ Yes:_____ ☐ No