In Focus
Vestibular Rehabilitation

Client Name :_________________
Date: _______________________

Dizziness Questionnaire

Which of the following phrases accurately describe your dizziness? Mark all that apply.

- ☐ Lightheaded
- ☐ Giddy
- ☐ Feeling like I'm going to fall
- ☐ Feeling like objects around me are spinning or turning
- ☐ Feeling like I'm spinning or turning but objects around me are not
- ☐ Tilting or leaning
- ☐ Swimming sensation in my head
- ☐ Headache
- ☐ Nausea
- ☐ Vomiting
- ☐ Tendency to veer off to the left when I am walking in the dark
- ☐ Tendency to veer off to the right when I am walking in the dark
- ☐ Feeling of pressure in my head
- ☐ Feeling of pressure in my ear(s)
- ☐ Tingling in my hands or toes or around my mouth
- ☐ Loss of consciousness

Indicate whether you are having any of the following symptoms. Mark all that apply.

- ☐ Difficulty hearing: Right _____ Left_____ Both______
- ☐ Ringing in the ear(s) Right _____ Left_____ Both______
- ☐ Pressure or stuffiness in the ear(s)
- ☐ Pain in the ear(s)
- ☐ Discharge from the ear(s)
- ☐ Blurred vision
- ☐ Double vision
- ☐ Numbness in the face or extremities
- ☐ Loss of consciousness
- ☐ Difficulty swallowing

Do any of the following make your dizziness worse?

- ☐ Hunger
- ☐ Menstrual period
- ☐ Bending head forwards or backwards
- ☐ Turning head to either side
- ☐ Coughing
- ☐ Bowel movements
- ☐ Stress
- ☐ Fatigue

- [] Drinking alcohol
- [] Flying
- [] Driving/Riding in moving vehicle
- [] Heights
- [] Caffeine
- [] Tobacco
- [] A particular medication
- [] Other:_____________________

Therapists Signature______________________