



THE CONDE CENTER

For Chiropractic Neurology

Vestibular Intake Form:

Patient Name: _____ Date: _____

Please answer the following questions as best as you can as they relate to you:

1. Please describe below your complaint in your own words *without* using the word dizzy:

2. How would you describe your complaint (Circle all that apply):
Dizziness Vertigo Unsteadiness Giddiness Lightheadedness

Other: _____

3. Have you seen anyone else for this present complaint?

No

Yes

If yes, please complete the following:

Who have you seen? _____

What treatments have you received?

What were the outcomes?

4. Have you ever experienced this type of problem before?

No

Yes

If yes please complete the following:

When & how many times did you have these dizzy spells?

Did you see anyone for your past dizziness?

What treatments did you receive?

What were the outcomes?

5. Do you ever have any of the following sensations?

Spinning in circles? If yes, then describe the direction?

Falling to one side? If yes, then describe the direction?

The world is spinning around you? If yes, then describe the direction?

You are spinning around the world? If yes, then describe the direction?

6. Because of this present problem, have you had any falls?

Yes

No

If yes, have you injured yourself from falling? Please describe.

7. The following questions refer to a typical "dizzy spell."

When did you notice your first dizzy spell?

Please describe in your own words where you were & how your first dizzy spell came on:

Were you taking any medication, over the counter or prescribed, at the time that these symptoms began? If yes, please explain.

Does anything trigger the onset of your dizzy spells? If yes, please describe:

Did you have a recent cold or flu prior to your recent dizzy spells?

Yes

No

How often do these dizzy spells occur? _____

How long do these dizzy spells last? _____

Are you completely free of your dizziness between attacks? _____

Does your dizziness occur mainly when you sit-up or stand-up quickly?

Yes

No

Are there certain positions that you are mainly dizzy in? If yes, please describe:

Are you dizzy even when you're lying down? _____

Do you have difficulty getting into bed? _____

Does rolling over in bed worsen your present problem? _____

Do fast head movements increase your present problem? _____

Do you have difficulty reading? _____

Does looking up make your dizzy spells worse? _____

Does walking down the aisle of a supermarket make your problem worse? _____

Do you have trouble walking in the dark? _____

Are the dizzy spells better when you lie down or sit perfectly still? _____

Does anything alleviate your dizzy spells? _____

Does anything make them worse? _____

8. The next questions relate to other sensations or symptoms you may have:

Do you also get nauseated when having a dizzy spell? _____

Do you ever black out or faint with your dizzy spell? _____

Do you ever experience fullness, pressure, or ringing in your ears? _____

Have you experienced pain or discharge from your ears? _____

Have you had any hearing loss? _____

Have you had any severe or recurrent headaches? _____

Have you noticed any visual problems such as blurry or double vision? _____

Have you ever had any of the following: Clumsiness. Uncoordinated movement.

Trouble with smooth movement of arms.

Trouble with smooth movement of legs. None of the above.

Do you stumble, stagger, or side-step when walking? _____

Do you drift to one side when you walk? _____

Are you having any problems with concentration or memory loss? _____

Have you had any recent head trauma? _____

Did you experience any trauma around or before the time that your dizzy spells began?

9. These questions relate to how your dizziness or unsteadiness relates to your daily life :

How frustrated do these problems make you? Somewhat, Moderately, or Extremely.

Does this problem restrict your travel? _____

Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered & for us by your doctor at The Conde Center. Any disclosure is outlined in our privacy policies.

Patient Signature _____

Date _____