Lantzville Wellness Centre

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VESTIBULAR INTAKE FORM

Have you experienced any of the following symptoms? Please check the box that applies to you.

	YES	NO
Spinning		
Tilting		
Ringing in the ears		
Swaying or feeling off balanced (pulled to one side)		
Nausea and/or vomiting		
Motion sickness		
Dizziness, light headedness		
The feeling of visual motion that happens when your eyes are open (Oscillopsia)		
Sensation of seeing double with the images lined up vertically (Vertical Diplopia)		
Migraines		
Hearing loss		
Vision loss		
Loss of balance		

When did you first notice these symptoms? _____

Have you recently had/ experienced any of the following? If yes, when?

	YES	NO	When?
Head injury (whiplash, concussion)			
Fall			
Ear infection			
Antibiotics			
Stroke			
Neck pain			

Have you ever been diagnosed or told you have any of the following?

	YES	NO
Meniere's disease		
Benign paroxysmal positional vertigo (BPPV)		
Vestibular neuritis		

Print Name:_____ Date:_____ Signature:_____

Therapist Name:_____ Therapist Signature:_____