Mankato Clinic

(Patient Label)
Patient Name:
DOB:
Age:
Date:

PHYSICAL THERAPY
DIZZINESS QUESTIONNAIRE

When did your symptoms start? ____________________

Are your symptoms: _____Increasing _____Staying the same _____Decreasing

What primary symptoms are you having? Check all that apply:

____Blacking out/fainting ____Falling ____Lightheaded ____Tingling hands/feet/lips
____Blurred vision ____Headaches/frequency ____Nausea/vomiting ____Unsteadiness
____Dizziness ____Hearing loss ____Neck pain ____Vertigo (spinning)
____Ear pain ____Imbalance ____Ringing in ears ____Weakness

Do you experience spells of vertigo (a sense of spinning)? ____Yes ___No

Do you experience a sense of being off-balance (disequilibrium)? ____Yes ____No

If YES, how long do these spells last? ___ seconds ___ minutes ___ hours ___ days

When was your last episode/spell? ___ today ___ this week ___ 2 weeks ago ___ a month ago ___ other

Describe your episodes/spells (check all that apply):

___ Spontaneous ___ Worse with fatigue ___ Occur when laying down
___ Caused by movement ___ Worse in the dark ___ Occur when sitting
___ Caused by position changes ___ Worse outside ___ Occur when walking
___ Caused by sneezing/loud noises/blowing nose ___ Worse on uneven surfaces ___ Occur when standing still

Have you fallen (to the ground or floor)? ____Yes ____No

Have you had <u>near falls</u> (where if you hadn't grabbed something or someone you would have fallen?) ____Yes ____No

What previous treatments have you had for this condition? ____

Have you had any tests done for your condition? ____

What activities do you have difficulty performing due to your symptoms? Check all that apply:

____Bending ____Recreational activities ____Walking in busy environments _____Driving
____Walking ____Transitional movements ____Turning head _____ Reading
____Stairs ____Standing ____Other____