

NEURODIAGNOSTIC INTAKE

Patient Name: _____ Date of Birth: _____

Provider Name: _____ Appt Date: _____

Sex: Male Female

CURRENT SYMPTOMS

Which of the following best describes your symptoms?

Imbalance Falling more often World spinning around you You feel as if YOU are spinning; the world is not spinning

Nausea Lightheadedness Other: _____

How long do your symptoms last without stopping?

Seconds Minutes Hours Days Nausea Symptoms are constant

Did any of the following occur prior to your symptom onset? (Check all that apply)

Head trauma Motor vehicle accident Upper respiratory infection Change in medication A fall

A virus or infection, e.g., shingles, cold sores, COVID-19 Surgery A stressful event or high stress Other: _____

Choose one:

Have your symptoms improved/ changed/ stayed the same since they began?

If improved or changed: How so? _____

Does anything make your symptoms better? _____

BALANCE & FALL SYMPTOMS (CHOOSE YES OR NO)

Have you fallen in the past year? Yes No

If yes: How many times? _____

If no: Have you experienced "near falls" but caught yourself? _____

Are you afraid of falling? Yes No

Are you veering/leaning while walking? Yes No

If yes: Which direction? Right Left Both

Do you have neuropathy, numbness or tingling in your feet or legs? Yes No

Has your exercise decreased? Yes No

If yes: Approximately when? _____

Orthopedic injuries? Yes No

If yes: Please explain: _____

DIZZINESS SYMPTOMS

Do you have a history of migraines? Yes No

If yes: When was your most recent migraine? _____

Do any of the following trigger your symptoms? (Check all that apply)

Increased stress Skipping a meal Not drinking enough water

Changes in weather Certain foods: _____

Do any of the following accompany or occur immediately prior to an episode of your symptoms? (Check all that apply)

- Headaches Neck pain Hearing loss (Right Left Both) Fullness in your ear(s) (Right Left Both)
 Ringing in your ear(s) (Right Left Both) Shimmers or sparkles in your vision Sensitivity to light, sound, smell

Choose Yes or No.

- My dizziness is intense but only lasts for seconds or minutes. Yes No
I get dizzy when I turn over in bed. Yes No
I get short-lasting, spinning dizziness that happens when I bend down to pick something up. Yes No
I get short-lasting, spinning dizziness that happens when I go from sitting to lying down. Yes No
I can trigger my dizzy spells by placing my head in certain positions. Yes No
I have had a single severe spell of spinning dizziness that lasted for hours to a day. Yes No
After my big episode of dizziness, I could not walk for days without falling over. Yes No
I had a spell of spinning dizziness that lasted for hours after I had a cold, virus or flu. Yes No
I had hearing loss in one ear at the same time that I had a long episode of spinning dizziness. Yes No
I have spells where I get dizzy, and it is difficult for me to breathe. Yes No
I feel dizzy all of the time. Yes No
I am anxious most of the time. Yes No
I am bothered by patterns, screens, e.g., supermarkets. Yes No
My symptoms increase when I go from lying down to sitting or sitting to standing. Yes No
When I cough or sneeze, I get dizzy. Yes No
I get dizzy when I strain to lift something heavy. Yes No
When I speak, my voice sounds abnormally loud to me. Yes No
My dizziness is provoked by head movements (up/down and right/left). Yes No
My head is heavy like a bowling ball. Yes No
I have a headache that is in or starts in the back of my head. Yes No
When I sit up from lying down or stand up from sitting, I experience a few seconds of dizziness. Yes No

MEDICAL HISTORY

Are your blood sugar, blood pressure and thyroid levels well controlled? Yes No

Do you have any known eye/vision issues? Yes No

If yes: Please explain: _____

Do you have hearing loss? Yes No

If yes: Which ear? Right Left Both

If yes: Was it sudden? Yes No

Do you wear hearing aids? Yes No

I am experiencing ear pain/ringing/drainage/fullness. Yes No

If yes: Which ear? Right Left Both

IF APPLICABLE: FEMALE HORMONAL HISTORY

Are you pre/peri/post-menopausal? Yes No

Did you have a hysterectomy? Yes No

If yes: When? _____

Have you had any changes to your contraceptives? Yes No

If yes: When? _____

Do you have a known hormonal imbalance? Yes No

If yes: Are you being treated for this issue? Yes No