Kos/Danchak
AUDIOLOGY & HEARING AIDS

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: _____

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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