

DIZZINESS QUESTIONNAIRE

Name: _____

Date: _____

PLEASE ANSWER ALL QUESTIONS

- I. When you are dizzy, do you experience any of the following sensations? Please read the entire list first. Then check either the first box for “yes” or the second box for “no” for each number to best describe the sensations you have when you are dizzy.

YES NO

- | | | |
|-----|-----|--|
| ___ | ___ | 1 Lightheadedness |
| ___ | ___ | 2. Swimming sensation in the head |
| ___ | ___ | 3. Feeling you are going to faint |
| ___ | ___ | 4. Blacking out |
| | | 5. Tendency to fall: |
| | | To the right |
| ___ | ___ | To the left |
| ___ | ___ | Forward |
| ___ | ___ | Backward |
| ___ | ___ | 6. Objects spinning or turning around you |
| ___ | ___ | 7. Sensation that you are turning inside with outside objects remaining stationary |
| | | 8. Loss of balance when walking |
| | | Veering to the right |
| ___ | ___ | Veering to the left |
| ___ | ___ | 9. Headache |
| ___ | ___ | 10. Nausea |
| ___ | ___ | 11. Vomiting |
| ___ | ___ | 12. Pressure in the head |
| ___ | ___ | 13 Other – |

Describe: _____

- II. Please check the box for either “yes” or “no” and fill in the blank spaces.

YES NO

1. When did dizziness first occur?

- ___ ___ 2. Are you dizzy all of the time?

___ ___ 3. Or does it come and go? How often?

_____ How long does it last?

___ ___ 4. Can you tell when an attack is about to start? How?

___ ___ 5. Are you completely free of dizziness between attacks?

___ ___ 6. Or do you have symptoms between attacks?

Describe: _____

___ ___ 7. Does change of head or body position make you dizzy?

___ ___ 8. Do you have trouble walking in the dark?

___ ___ 9. When you are dizzy, can you stand up unsupported?

DIZZINESS QUESTIONNAIRE

Page Two

YES NO

___ ___ 10. Do you know of any possible cause of your dizziness? What?

___ ___ 11. Do you do anything that will:
Stop your dizziness or make it better? What?

___ ___ Make your dizziness worse? What?

___ ___ Bring on an attack? What?

___ ___ 12. Is there any relationship between eating and your dizziness?
What?

___ ___ 13. Do you think you eat a lot of animal fat? _____

___ ___ 14. Do you think you eat a lot of salt? _____

___ ___ 15. Do you drink coffee or caffeinated sodas? How many cups per day?

___ ___ 16. Do you drink alcohol? How much?

___ ___ 17. Do you use tobacco in any form? How much?

your ___ ___ 18. Were you exposed to any irritating fumes, paints, etc. at the onset of
dizziness? What?

___ ___ 19. Do you take any medications regularly?

What?

-
- ___ 20. Do you have any allergies? To what? _____
-
- ___ 21. Have you ever had a head injury? When? _____
-
- ___ 22. Do you think you are under any unusual stress or tension? _____
- ___ 23. Has anyone in your family had similar dizziness? Who? _____
-
- ___ 24. Any history of whiplash or neck injury? _____
- ___ 25. Any chiropractic neck adjustments? _____

III. Do you have any of the following symptoms? Check either "yes" or "no" and circle the ear involved

- | | YES | NO | | Right | Left |
|------|-----|-----|---|-------|------|
| Both | ___ | ___ | 1. Difficulty in hearing? | | |
| Both | ___ | ___ | 2. Noise in your ears? | | |
| | | | Describe the noise: _____ | | |
| | ___ | ___ | 3. Does the noise change around the time you are dizzy? How? | | |
| Both | ___ | ___ | 4. Fullness, stuffiness or pressure in your ears? | | |
| Both | ___ | ___ | 5. Do you have pain in your ears? | | |
| Both | ___ | ___ | 6. Discharge from your ears? | | |
| | ___ | ___ | 7. Have you ever been exposed to loud noise? Where and When? | | |
| | | | For how long? _____ | | |
| Both | ___ | ___ | 8. Did you wear hearing protection? Ear plugs Ear muffs | | |
| | ___ | ___ | 9. Do some sounds seem annoyingly loud since your dizziness began? | | |
| | ___ | ___ | 10. Has anyone in your family had a hearing problem? Who? | | |
-

DIZZINESS QUESTIONNAIRE

Page Three

IV. Have you experienced any of the following symptoms? Please check either "yes" or "no" and circle either "constant" or "sometimes." If "sometimes," write in how often.

YES	NO		
___	___	1. Double vision	Constant
		Sometimes _____	
___	___	2. Blurred vision	Constant
		Sometimes _____	
___	___	3. Temporary blindness	Constant
		Sometimes _____	
___	___	4. Numbness of your face	Constant
		Sometimes _____	
___	___	5. Weakness of your face	Constant
		Sometimes _____	
___	___	6. Numbness of your arms or legs	Constant
		Sometimes _____	
___	___	7. Weakness in your arms or legs	Constant
		Sometimes _____	
___	___	8. Clumsiness in your arms or legs	Constant
		Sometimes _____	
___	___	9. Mental confusion	Constant
		Sometimes _____	
___	___	10. Loss of consciousness	Constant
		Sometimes _____	
___	___	11. Difficulty with speech	Constant
		Sometimes _____	
___	___	12. Trouble swallowing	Constant
		Sometimes _____	