

Chiropractic Neurology & Wellness Center

www.cnwcenter.com

In order to thoroughly understand your condition, the doctor requests that you please answer the following questions as accurately as possible.

Name: _____ Age: _____ Male/Female

When was your **first** episode of dizziness? _____

How long did it last? ●Seconds ●Minutes ●Hours ●Days

When was your **last** episode of dizziness? _____

How long did it last? ●Seconds ●Minutes ●Hours ●Days

Prior to the last attack, did you: ●Have a cold? ●Hit your head?

How many dizzy attacks have you suffered? _____

How often does it return? ●Daily ●Weekly ●Monthly ●Yearly

Are you completely symptom-free between attacks? Y N

Do you have any warning prior to your attack? Y N _____

Please Circle if heat, fatigue, emotional stress, hunger, anxiety, alcohol, certain foods or menstrual periods have any effect of your dizziness?

Does anything stop your dizziness? _____

Would you describe your "dizziness" as one or more of the following?

- Room Spinning ●Yourself Spinning ●Unsteadiness ●Feeling Drunk
- Light-headed/Faint ●Swimming ●Walking on Pillows

Do you have a tendency to Fall? ●Forward ●Backward ●Right ●Left

Do you feel as if you are being pulled? ●Forward ●Backward ●Right ●Left

Circle the sensations you experience with your dizziness?

- Nausea ●Vomiting ●Sweating ●Headache ●Confusion ●Loss of Consciousness
- Heart Palpitations/Arrhythmia ●Chest Tightness ●Shortness of Breath
- Visual Disturbance? (Blurred Vision, Double Vision, See Stars) ●Eyes get "stuck" when reading
- Numbness? Face/Arms/Legs ●Weakness or Clumsiness? Face/Arms/Legs
- Difficulty with Speech? ●Difficulty Swallowing? ●Abnormal Movement (Tremor)

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Do you experience any of the following noises with your dizziness?

● Buzzing ● Ringing ● Roaring ● Popping/Crackling ● Voices

Do you have trouble hearing **with your dizziness**? R L Both Ears

Do you have fullness in your ears **with your dizziness**? R L Both Ears

Do you have pain in your ears **with your dizziness**? R L Both Ears

Have you noticed discharge/drainage from your ears? R L Both Ears

Please Circle if your symptoms of dizziness **worsen**, even slightly, when you:

Turn your head quickly? ● Left ● Right

Bend your head quickly? ● Look Up (i.e.: in shower, in cupboard)

● Look Down

Please Circle if your symptoms of dizziness **worsen**, even slightly, when you:

Lie down in bed? Y N

Lie down in bed and turn head Left or Right?

Roll over in bed? Left or Right?

Sit up in bed? Y N

Look under the bed? Y N

Please Circle if your symptoms of dizziness **worsen**, even slightly, when you:

Bend down (to tie shoes, pick something up?) Y N

Straighten up from bending down? Y N

Stand up too quickly? Y N

Please Circle if your symptoms of dizziness **worsen**, even slightly, when you:

● Cough ● Sneeze ● Blow your Nose ● Strain to Lift Something ● Hear a loud noise

● Rub/Tug your ear? ● Walk (hold the wall, railing) ● Run ● Climb Up or Down Stairs

● Ride in a: Vehicle Elevator Escalator

● Watch a Movie (special effects that move fast) ● Scroll down page on the computer

How many car accidents have you been in over the last five years? _____

Have you hit your head recently (home, work, sporting activity?) _____

Have you ever been knocked out? Y N When? _____

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Have you ever had an I.V. antibiotic during a hospital stay? Y N When? _____

Do you have a cardiologist? Y N Whom? _____

Do you have ●Anemia ●Diabetes ●High/Low blood pressure ●High cholesterol ●Allergies
●Depression ●Seizures ●Panic Attacks ●Hyperventilation

In general, do you have **trouble hearing without dizziness?** R L Both Ears

When did you first notice difficulty hearing? _____

Was the hearing loss: Sudden? Gradual?

Have you had your ears evaluated by an Ear Specialist (ENT, Audiologist?) Y N

Whom: _____

When and where was your last hearing test? _____

Do you wear a hearing aid? R L Both Ears

Have you ever had ear surgery? (Tubes, etc.) Y N When/Where? _____

When you are not dizzy, do you hear any of the following noises?

●Buzzing ●Ringing ●Roaring ●Popping/Crackling ●Voices

What ear? R L Both

When did you first notice the noise? _____

Is the noise: ●Constant ●Intermittent?

Have you ever been exposed to loud noise (machines, music)? Y N

Please describe how your quality of life has deteriorated with this affliction:

Print Patient Name

Patient Signature

Date