SYNERGY
Sports · Wellness · Institute

Vestibular Localization Form

PART 1 INSTRUCTIONS: PATTERNS OF DIZZINESS

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please answer every question, do not skip any questions. Circle yes or no where asked.

NAME: DATE:

Patterns of Dizziness

How would you explain your dizziness:

Lightheaded	Yes / No	
Disorientation	Yes / No	
False sense of motion that you are moving	Yes / No	If yes, in which direction _____
False sense of motion the world is moving	Yes / No	If yes, in which direction _____

Please describe your dizziness without using the word "dizzy":

Are your dizziness symptoms (circle one): Recent (first episode) Reoccurring Chronic

What is the typical duration of your symptoms (circle one)?
A few seconds Several seconds to a few minutes Several minutes to one hour Days Weeks

Do you have hearing loss with your vertigo?	Yes / No
Do you have any ringing in your ear with your vertigo?	Yes / No
Is there any correlation with timing of your symptoms and taking a new medication (aspirin, antibiotics, diuretics, etc.)?	Yes / No Maybe
Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins?	Yes / No Maybe
Can your symptoms of dizziness be reduced by visually fixating on a target?	Yes / No
Are your symptoms of dizziness worse in the dark?	Yes / No
Are there any other symptoms you experience besides false sense of motion? What? (ex. Nausea, anxiety, racing heart rate, etc.) _____	Yes / No
Is there anything that can aggravate your vertigo? What?_____	Yes / No
Does anything help your symptoms? What?_____	Yes / No

Do any of the following movements cause you to feel disorientated or dizzy?

Turning to the right	Yes / No
Turning to the left	Yes / No
Suddenly stopping in a car or a plane landing	Yes / No
Suddenly starting to move forward in a car or plane	Yes / No
Looking out the window of a train or moving vehicle with your back facing the direction of movement	Yes / No
Looking out the window of a train or moving vehicle with your front facing the direction of movement	Yes / No
Moving side-to-side	Yes / No
Suddenly moving up or down on an elevator	Yes / No

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PART 2 INSTRUCTIONS: DIZZINESS SYNDROMES

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please select yes or no.

Perilympathic Fistula and Superior Canal Dehiscence	Yes / No
Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear?	Yes / No
Did your dizziness start after heavy weight bearing or excessive straining with bowel movements?	Yes / No
Can sneezing, straining, or changes of pressure trigger your dizziness?	Yes / No
Can putting your head down to one side trigger your dizziness?	Yes / No
Can loud noises or sounds at times trigger your dizziness?	Yes / No
Have you started to notice your own voice much louder than before?	Yes / No
Have you notice any distortions of sensations of sound?	Yes / No
Benign Paroxysmal Positional Vertigo	
Can positional changes such as turning over in bed, bending over and then straightening up, or tilting your head trigger your symptoms?	Yes / No
Are your symptoms of dizziness prompted by eye or head movements and then decrease in less than one minute?	Yes / No
Does your dizziness become less noticeable each time you repeat the same movement?	Yes / No
Do your episodes of dizziness come in sudden and brief spells?	Yes / No
Vestibular Neuronitis	
Did your dizziness come on suddenly?	Yes / No
Did your dizziness start after a recent viral or bacterial infection?	Yes / No
Do you have a history of Herpes Zoster outbreaks?	Yes / No
Did your dizziness start during a period of exhaustion or weakened immune system?	Yes / No
Meniere's	
Do you notice a feeling of fullness in the ear or on the side of your head accompanying your episodes of dizziness?	Yes / No
Do you have episode of ringing in your ear accompanying your episodes of dizziness?	Yes / No
Have you experienced two or more episodes of vertigo lasing at least 20 minutes each?	Yes / No
Vestibular Migraine	
Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches?	Yes / No
Do you experience a throbbing headache before or after your episodes of dizziness?	Yes / No
Do you become extremely sensitive to light and sound before or after you episodes of dizziness?	Yes / No
Have you noticed your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG?	Yes / No

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PART 3 INSTRUCTIONS: PREVIOUS DIAGNOSIS

The purpose of this questionnaire is to identify difficulties you may be experiencing.

Previous Diagnosis

Have you ever been diagnosed or suffered from with the following conditions (circle all that apply):

- Benign Proxysmal Positional Vertigo (BPPV)
- Meniere's Disease
- Ototoxicty
- Otosclerosis
- Tinnitus
- Hearing Loss
- Acoustic Neuroma
- Stroke
- Migraine
- Transient Ischemic Attack (TIA)
- Perilympathic Fistula
- Superior Canal Dehiscence
- Endolymphatic hydrop
- Autoimmune Inner Ear Disease
- Cervigogenic Syndrome
- Vestibulopathy
- Cerebellum Disease
- Cholesteatoma
- Enlarged Vestibular aqueduct
- Vestibular Neuritis or Labyrinthitis
- Mal de Debarqument
- Neurototoxcity
- Trauma to your ear
- Trauma to your head/brain
- Concussion

NAME: DATE: