The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

Physical Therapy

Pre-Examination Questionnaire

Dizziness / Vertigo

Preferred Name:_____ Date of Birth:_____ Occupation:_____

Date of onset of symptoms_____ Do you wear hearing aids?_____

Does looking up increase your problem?	Yes	No	Sometimes
Do quick movements of your head increase your problem?	Yes	No	Sometimes
Because of your problem do you feel frustrated?	Yes	No	Sometimes
Is it difficult for you to concentrate with your condition?	Yes	No	Sometimes
Do you restrict travel for business or recreation?	Yes	No	Sometimes
Does walking in the supermarket increase your problem?	Yes	No	Sometimes
Do you have difficulty getting in or out of bed?	Yes	No	Sometimes
Does turning over in bed increase your problem?	Yes	No	Sometimes
Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
Because of your problem, do you avoid heights?	Yes	No	Sometimes
Is it difficult to go for a walk by yourself?	Yes	No	Sometimes
Are you comfortable leaving your home by yourself?	yes	No	sometimes
Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
Does bending over increase your problem?	Yes	No	Sometimes

Is it difficult to walk around your house in the dark?	Yes	No	Sometimes
Is it difficult to do strenuous homework or yard work?	Yes	No	Sometimes
Are you afraid to stay home alone with your condition?	Yes	No	Sometimes
Are you afraid people might think you are intoxicated?	Yes	No	Sometimes
Have you been embarrassed in front of others?	Yes	No	sometimes
Are you depressed because of your problem?	Yes	No	Sometimes
Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
Do you feel handicapped due to this problem?	Yes	No	Sometimes
Does performing more ambitious activities like house cleaning, sports, and dancing increase your problem?	Yes	No	Sometimes
Does your problem significantly restrict your participation in social activities, IE: going out to dinner, the movies or parties?	Yes	No	Sometimes

Do you use a: Cane_____, Walker or rollator _____, Manual Wheelchair _____, Motorized Wheelchair_____

Does your home have: Stairs with a railing _____Stairs, no railing_____ Elevator_____ Ramps_____

Employment: (*Full time / Part time)(In Home / Out of Home) Retired / Student / Homemaker / Unemployed*

Date of your last vision exam _____

What are you leisure activities?_____

What are your goals? What activities would you like to be able to do?

1. _____
2. _____

Is this a MVA or L&I / Work related Injury?_____ **DOI**_____

Thank you for providing us with this information