

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Describe the major reason for your appointment: \_\_\_\_\_

### Do you experience your symptoms as a result of the following precipitating factors?

- |  |  |
|--|--|
| <input type="checkbox"/> sitting to lying on your back | <input type="checkbox"/> prolonged standing                |
| <input type="checkbox"/> rolling over in bed           | <input type="checkbox"/> while recumbent and motionless    |
| <input type="checkbox"/> head flexion and extension    | <input type="checkbox"/> wearing tight collar              |
| <input type="checkbox"/> lying on your back to sitting | <input type="checkbox"/> hyperventilation                  |
| <input type="checkbox"/> any head movement             | <input type="checkbox"/> coughing                          |
| <input type="checkbox"/> caffeine                      | <input type="checkbox"/> urination                         |
| <input type="checkbox"/> exercise                      | <input type="checkbox"/> rapid rising from sitting         |
| <input type="checkbox"/> alcohol                       | <input type="checkbox"/> prolonged neck extension-rotation |
| <input type="checkbox"/> emotional stimuli             | <input type="checkbox"/> menstrual period                  |
| <input type="checkbox"/> pain                          | <input type="checkbox"/> arm activity                      |
| <input type="checkbox"/> fatigue                       | <input type="checkbox"/> anxiety                           |
| <input type="checkbox"/> fear                          |  |

### Do you have any of these associated symptoms?

#### Pain

- |   |   |
|---|---|
| <input type="checkbox"/> Headache in combination with neck pain                 | <input type="checkbox"/> Abdominal pain                           |
| <input type="checkbox"/> Chest, neck and arm pain                               | <input type="checkbox"/> Unilateral and pulsating headache        |
| <input type="checkbox"/> External ear pain with swallowing, talking or coughing | <input type="checkbox"/> Sudden onset neck and occipital headache |

#### Visual abnormalities

- |   |  |
|---|--|
| <input type="checkbox"/> Loss of colour vision            | <input type="checkbox"/> Constant double vision                |
| <input type="checkbox"/> Visual field deficits            | <input type="checkbox"/> Tilt illusion (objects appear tilted) |
| <input type="checkbox"/> Blurry vision                    | <input type="checkbox"/> Sensitivity to light                  |
| <input type="checkbox"/> Double vision with head movement |  |

#### Mental and psychological status

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Decreased cognition | <input type="checkbox"/> Stupor     |
| <input type="checkbox"/> Acute confusion     | <input type="checkbox"/> Anxiety    |
| <input type="checkbox"/> Memory deficits     | <input type="checkbox"/> Depression |

#### Other

- |  |  |
|--|--|
| <input type="checkbox"/> Excessive sweating      | <input type="checkbox"/> Coughing                                  |
| <input type="checkbox"/> Hot flushed skin        | <input type="checkbox"/> Cyanosis (blue discoloration of the skin) |
| <input type="checkbox"/> Myoclonus               | <input type="checkbox"/> Swelling of the legs                      |
| <input type="checkbox"/> Muscular twitching      | <input type="checkbox"/> Claudication                              |
| <input type="checkbox"/> Spastic bladder         | <input type="checkbox"/> Feeling of choking                        |
| <input type="checkbox"/> Discharge from the ear  | <input type="checkbox"/> Feeling of unreality                      |
| <input type="checkbox"/> Thirst                  | <input type="checkbox"/> Fear of losing control                    |
| <input type="checkbox"/> Polyuria                | <input type="checkbox"/> Fear of dying                             |
| <input type="checkbox"/> Polyphagia              | <input type="checkbox"/> Insomnia                                  |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Gastro-esophageal reflux                  |
| <input type="checkbox"/> Palpitations            | <input type="checkbox"/> Drop attacks                              |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Remitting-relapsing neuro function        |

**MEDICAL HISTORY**

**Have you in the past been diagnosed with or currently have (check all that apply):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Head trauma  | <input type="checkbox"/> Recent mumps                                | <input type="checkbox"/> Thromboembolic disease (blood clots)   |
| <input type="checkbox"/> Neck trauma  | <input type="checkbox"/> Recent poliomyelitis                        | <input type="checkbox"/> Neck degeneration  |
| <input type="checkbox"/> Inner or middle ear infection                              | <input type="checkbox"/> Mononucleosis (Epstein-Barr, Mono)          | <input type="checkbox"/> Recurrent episodes of vertebrobasilar ischemia (limited blood supply to the brain) |
| <input type="checkbox"/> Middle ear surgery   | <input type="checkbox"/> Recent viral infection                      | <input type="checkbox"/> Visual impairments   |
| <input type="checkbox"/> Inner ear degeneration                                     | <input type="checkbox"/> Recent inoculation                          | <input type="checkbox"/> Hearing impairments  |
| <input type="checkbox"/> Recent upper respiratory tract infection                   | <input type="checkbox"/> Multiple sclerosis                          | <input type="checkbox"/> Migraine or migraine-related disorders   |
| <input type="checkbox"/> Recent bacterial infection                                 | <input type="checkbox"/> Lung cancer                                 | <input type="checkbox"/> Joint replacement  |
| <input type="checkbox"/> Syphilis   | <input type="checkbox"/> Ovarian cancer                              | <input type="checkbox"/> Other orthopaedic surgical procedure   |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Hodgkin's disease (lymphatic cancer)        | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Rheumatoid arthritis                                       | <input type="checkbox"/> Breast cancer                               | <input type="checkbox"/> Back problem   |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Heart disease                               |   |
| <input type="checkbox"/> Crohn's disease  | <input type="checkbox"/> Diabetes                                    |   |
| <input type="checkbox"/> Polyarteritis (auto-immune disease affecting the arteries) | <input type="checkbox"/> Chronic obstructive lung disease            |   |
| <input type="checkbox"/> AIDS   | <input type="checkbox"/> Atherosclerosis (hardening of the arteries) |   |
| <input type="checkbox"/> Recent chicken pox   |  |   |

**Have you recently:**

- |   |  |
|---|--|
| <input type="checkbox"/> Been in contact with rodents | <input type="checkbox"/> Coughed, sneezed or strained forcefully |
| <input type="checkbox"/> Gone diving                  | <input type="checkbox"/> Lifted very heavy items                 |
| <input type="checkbox"/> Gone flying                  |  |

**Has a member of your family ever been diagnosed with or currently have any of the following, (check all that apply):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Familial paroxysmal ataxia | <input type="checkbox"/> Otosclerosis                | <input type="checkbox"/> Migraine               |
| <input type="checkbox"/> Meniere's disease          | <input type="checkbox"/> Ataxia-telangiectasia       |   |
| <input type="checkbox"/> Vertebrobasilar migraine   | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Spinocerebellar ataxia |
| <input type="checkbox"/> Coronary artery disease    |  | <input type="checkbox"/> Freidreich's ataxia    |

**Have you used or are you currently using (check all that apply):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol           | <input type="checkbox"/> Gentamycin                         | <input type="checkbox"/> Potassium     |
| <input type="checkbox"/> Amikacin          | <input type="checkbox"/> Heroin                             | <input type="checkbox"/> Procainamide  |
| <input type="checkbox"/> Angel dust        | <input type="checkbox"/> Isoniazid                          | <input type="checkbox"/> Propranolol   |
| <input type="checkbox"/> Antidepressants   | <input type="checkbox"/> Kanamycin                          | <input type="checkbox"/> Pyridoxine    |
| <input type="checkbox"/> Antihypertensives | <input type="checkbox"/> Levodopa                           | <input type="checkbox"/> Quinidine     |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Meprobamate                        | <input type="checkbox"/> Quinine       |
| <input type="checkbox"/> Barbiturates      | <input type="checkbox"/> Methyldopa                         | <input type="checkbox"/> Reserpine     |
| <input type="checkbox"/> Benzodiazepines   | <input type="checkbox"/> Metoclopramide                     | <input type="checkbox"/> Streptomycin  |
| <input type="checkbox"/> Bromocriptine     | <input type="checkbox"/> Monoamine-oxidase (MOA) inhibitors | <input type="checkbox"/> Taxol         |
| <input type="checkbox"/> Butyrophenones    | <input type="checkbox"/> Nitroglycerin                      | <input type="checkbox"/> Tetrabenazine |
| <input type="checkbox"/> Cis-platinum      | <input type="checkbox"/> Phencyclidine                      | <input type="checkbox"/> Tobramycin    |
| <input type="checkbox"/> Digitalis         | <input type="checkbox"/> Phentothiazines                    |  |
| <input type="checkbox"/> Diuretics         | <input type="checkbox"/> Phenytoin                          |  |
| <input type="checkbox"/> Ethchlorvynol     |   |  |