VERTIGO, DIZZINESS & BALANCE LOG

VETERAN INFORMATION AND BASELINE

Veteran Advocacy Group LLC | VA Accredited Claims Agent

Accreditation #60676 | POA Code KW9 | 272-257-1349 | claims@veteran-advocacy.com | www.veteran-advocacy-group.com

VETERAN INFORMATION

Veteran name	VA file number (last 4 only)	Log start date

Primary phone	Email	Representative / provider

CONDITION BASELINE

Diagnosis, if known	Treating provider	Driving / fall restrictions

Date symptoms began	Typical frequency	Typical severity (0-10)

CURRENT TREATMENT

Medication / device	Frequency	Benefit	Side effects

HOW TO USE THIS LOG

Record symptoms as soon as practical. Include frequency, severity, duration, treatment, and what the condition prevented or made difficult. Describe effects on employment, relationships, sleep, mobility, self-care, driving, and household activities. Record only events and limitations actually experienced. Keep related medical and employment records. Seek urgent care for dizziness with weakness, facial droop, speech difficulty, fainting, severe headache, or chest pain.

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SEVEN-DAY SYMPTOM AND FUNCTIONAL-IMPACT SUMMARY

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Veteran name	Week beginning	Week ending

DAILY SUMMARY

Date / time	Attack duration	Severity 0-10	Stagger / fall	Nausea	Hearing / tinnitus	Daily impact

WEEKLY FUNCTIONAL IMPACT

Total episodes / symptom days	Severe symptom days	Care or treatment contacts

Work hours lost	Appointments / activities missed	Help needed from another person

Weekly notes, patterns, triggers, or changes:

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DETAILED SYMPTOM OR EPISODE RECORD

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Veteran name _____

Date _____

Condition / affected area _____

SYMPTOM OR EPISODE DETAILS

[ ] Spinning [ ] Lightheadedness [ ] Staggering [ ] Fall / near fall [ ] Nausea / vomiting

[ ] Hearing change [ ] Tinnitus [ ] Head movement trigger

Attack start / end _____

Position or trigger _____

Symptoms and severity _____

Staggering / fall / injury _____

Hearing or tinnitus change _____

TREATMENT, RESPONSE & WITNESSES

Treatment / recovery time _____

Driving, work, or activity impact _____

Medication / treatment used _____

Relief: none / partial / complete _____

Time until recovery _____

FUNCTIONAL IMPACT

[ ] Continued normally [ ] Reduced activity [ ] Stopped activity [ ] Needed rest

[ ] Needed assistance [ ] Missed work [ ] Left early [ ] Missed appointment

Work or activity time lost _____

Person who observed / assisted _____

Provider contacted _____

Describe exactly what the symptoms prevented, interrupted, or required help completing:

_____

_____

_____

_____