

Do you experience a sense of spinning (**vertigo**)? YES NO

If YES, how long do these spells last? _____

When was the last time the vertigo occurred? _____

Is the vertigo :	Spontaneous	YES	NO
	Induced by motion	YES	NO
	Induced by position changes	YES	NO

Have you fallen (to the ground) YES NO

If YES, please describe _____

How often do you fall? _____ Have you injured yourself? YES NO

Do you stumble, stagger, or side-step while walking? YES NO

Do you drift to one side while walking? YES NO

If yes, to which side do you drift? RIGHT LEFT

Functional Status:

Are you independent in self-care activities? YES NO

Can you drive? YES NO

Are you working? YES NO NOT APPLICABLE

If NO, are you on medical disability? YES NO

Are you able to: watch TV comfortably? YES NO

go shopping? YES NO

read comfortably? YES NO

be in traffic? YES NO

For the following, please pick the **one** statement that best describes how you feel?

- ___ I have negligible symptoms
- ___ I have bothersome symptoms
- ___ I perform usual work duties but symptoms interfere with outside activities
- ___ Symptoms disrupt performance of both my usual work duties and outside activities
- ___ I am currently on medical leave or had to change jobs because of my symptoms
- ___ I have been unable to work for 1 year or have established permanent disability with compensation payments