BPPV Assessment

Date: ____________________

Name: ____ **DOB:** _____________________

Email: ____ **Family Dr.** ____

Occupation: ____ **Hobbies**:____

Date Problem Began: ___________________________________ Involved in an accident: ☐ Yes ☐ No

What do you hope to achieve as a result of treatment: ____

Symptoms

☐ Headaches
☐ Vertigo/Dizziness/Light-head
☐ Pins and Needles/Numbness
☐ Imbalance/Undulation/Spinning
☐ Nausea / upset stomach
☐ General Malaise
☐ Sleep Disturbance
☐ Recent unexplained weight change
☐ Double Vision/Eye Issues
☐ Loss of consciousness
☐ Difficulty Speaking
☐ Difficulty Swallowing

↓	Check those that apply to you	How often?	How Long?	Intensity? (0 = normal, 10 = severe)
	Constant Dizziness			
	Occurs Spontaneously			
	Provoked by Movement			
	Provoked by Environment			
	Provoked by?			

Describe your worst event:____

Describe your current symptoms:____

What makes it better?____

What makes it worse? ☐ Walking ☐ Elevators ☐ Bending ☐ Other ________________________
☐ Walking in the dark ☐ Drivers ☐ Reaching ________________________
☐ Unstable Surfaces ☐ Shopping ☐ Turning ________________________

Pain: ☐ Yes ☐ No

Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Medication: ☐ Steroids (past/present) ☐ Blood Thinners ☐ Other (Please list): ________________________

__________________ ____________________ ____________________ ______________________

Investigations – for this problem & date

☐ X-Ray ☐ CT Scan ☐ Other___________________________________
☐ MRI ☐ US Scan

Medical History

☐ Cancer (past or present)
☐ Radiation Therapy (last 6 months)
☐ Chemotherapy (last 6 months)
☐ Cardiac Pacemaker
☐ Heart Issues (past or present)
☐ Osteo/Rheumatoid Arthritis
☐ Osteoporosis
☐ Diabetes
☐ Surgeries
☐ Broken Bones
☐ Pregnant (or trying)
☐ Family History of Disease
____
☐ Other
____

Jacobsen Dizziness Inventory

		4 All	3 Most	2 Some	0 Never
1	Does looking up increase your problem?				
2	Does walking down the aisles of a supermarket without a cart increase your problem?				
3	Does performing more ambitious activities like sports, dancing, or household chores increase your problem?				
4	Do quick head movements increase your problem?				
5	Does turning over in bed increase your problem?				
6	Does walking on the lawn increase your problem?				
7	Does bending over increase your problem?				
Total					
8	Because of your problem do you restrict your travel for business or recreation?				
9	Because of your problem do you have difficulty getting into or out of bed?				
10	Does your problem significantly restrict your participation in social activities?				
11	Because of your problem do you have difficulty reading?				
12	Because of your problem do you have someone accompany you when you leave home?				
13	Because of your problem, is it difficult for you to take care of yourself (bathe, dress, prepare a meal)?				
14	Because of your problem, is it difficult to walk around your house in the dark?				
15	Because of your problem, do you avoid driving your car during the daytime?				
16	Because of your problem, is it difficult for you to go for a walk by yourself?				
17	Because of your problem, is it difficult for you to walk up and down stairs?				
18	Because of your problem, do you avoid driving your car in the dark?				
19	Does your problem interfere with your job or your household responsibilities?				
Total					
20	Because of your problem, is it difficult for you to concentrate?				
21	Because of your problem, do you feel frustrated?				
22	Because of your problem, are you afraid to stay home alone?				
23	Because of your problem, are you afraid people think you are intoxicated?				
24	Has your problem placed stress on your relationships with members of your family or friends?				
25	Because of your problem, are you depressed?				
Total					

Office Use Only

	All	**Most**	**Some**	**Never**	**Total**
P					
F					
E					