PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

Instructions: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes," "no," or "sometimes" to each question.

Answer each question as it pertains to your dizziness problem only.

	Yes (4)	Sometimes (2)	No (0)	Scale
1. Does looking up increase your problem?				P
2. Because of your problem do you feel frustrated?				E
3. Because of your problem do you restrict your travel for business or recreation?				
4. Does walking down the aisle of a supermarket increase your problem?				
5. Because of your problem do you have difficulty getting into or out of bed?				P
6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or to parties?				
7. Because of your problem do you have difficulty reading?				
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem?				
9. Because of your problem are you afraid to leave your home without having someone accompany you?				C
10. Because of your problem have you been embarrassed in front of others?				
11. Do quick movements of your head increase your problem?				P
12. Because of your problem do you avoid heights?				
13. Does turning over in bed increase your problem?				P
14. Because of your problem is it difficult for you to do strenuous housework or yardwork?				
15. Because of your problem are you afraid people may think that you are intoxicated?				
6. Because of your problem, is it difficult for you to go for a walk by yourself?				C
17. Does walking down a sidewalk increase your problem?				
18. Because of your problem is it difficult for you to concentrate?				
19. Because of your problem, is it difficult for you to walk around your house in the dark?				
20. Because of your problem are you afraid to stay home alone?				C
21. Because of your problem do you feel handicapped?				
22. Has your problem placed stress on your relationships with members of your family and friends?				E
23. Because of your problem are you depressed?				E
24. Does your problem interfere with your job or household responsibilities?				
25. Does bending over increase your problem?				P

POSITIONAL	CATASTROPHIC	EMOTIONAL	TOTAL SCORE

Jacobson GP & Newman CW (1990). "The Development of the Dizziness Handicap Inventory." *Arch Otolaryngol Head Neck Surg.* 116 (4); p424-427.

doi:10.1001/archotol.1990.01870040046011

0-15 no handicap indicated; 16-34 mild handicap; 35-52 moderate handicap; 53-100 severe handicap

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

The Dizziness Symptom Profile

The following pages contain statements with which you can agree or disagree. To what extent do you personally agree or disagree with these statements in regards to your dizziness? Use the following scale: 0 = Strongly disagree, 1 = Disagree, 2 = Not sure, 3 = Agree, 4 = Strongly Agree

		Strongly Disagree		Not Sure		Strongly Agree
1	My dizziness is intense but only lasts for seconds to minutes.	0	1	2	3	4
2	I have had a single severe spell of spinning dizziness that lasted days or weeks.	0	1	2	3	4
3	I have spells where I get dizzy and also have irregular heartbeats (palpitations).	0	1	2	3	4
4	I hear my voice more loudly in one ear compared to the other.	0	1	2	3	4
5	I am unsure of my footing when I walk outside.	0	1	2	3	4
6	I get dizzy when I turn over in bed.	0	1	2	3	4
7	I get dizzy when I am in open spaces and have nothing to hold onto.	0	1	2	3	4
8	I have a roaring sound in one ear only before or during a dizziness attack.	0	1	2	3	4
9	I am depressed much of the time.	0	1	2	3	4
10	I lost hearing in one ear after an attack of spinning dizziness.	0	1	2	3	4
11	I had a big dizzy spell that lasted for days where I could not walk without falling over.	0	1	2	3	4
12	I get dizzy when I sneeze.	0	1	2	3	4
13	There are times when I get dizzy and also have a headache.	0	1	2	3	4

		Strongly Disagree		Not Sure		Strongly Agree
14	I get dizzy when I strain to lift something heavy.	0	1	2	3	4
15	I get short-lasting, spinning dizziness that happens when I bend down to pick something up.	0	1	2	3	4
16	My hearing gets worse in one ear before or during a dizziness attack.	0	1	2	3	4
17	I had a single constant spell of spinning dizziness that lasted longer than 2-3 days.	0	1	2	3	4
18	When I get a headache I am very sensitive to sound (I try to find a quiet place to rest).	0	1	2	3	4
19	I get short-lasting, spinning dizziness that happens when I go from sitting to lying down.	0	1	2	3	4
20	I can trigger a dizzy spell by placing my head in a certain position.	0	1	2	3	4
21	I had a spell of spinning dizziness that lasted for days or weeks after I had a cold or flu.	0	1	2	3	4
22	I have a feeling of fullness or pressure in one ear before or during a dizziness attack.	0	1	2	3	4
23	I get headaches that hurt so badly that I am completely unable to do my daily activities	0	1	2	3	4
24	I have spells where I get dizzy and it is difficult for me to breathe.	0	1	2	3	4
25	I have a sensation of dizziness or imbalance daily or almost daily.	0	1	2	3	4
26	My vision changes before a headache begins.	0	1	2	3	4
27	I am unsteady on my feet all the time.	0	1	2	3	4
28	I am anxious much of the time.	0	1	2	3	4
29	When I cough I get dizzy.	0	1	2	3	4
30	When I get a headache I am very sensitive to light (I try to find a dark room to rest).	0	1	2	3	4
31	I feel dizzy all of the time.	0	1	2	3	4

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

PURDUE UNIVERSITY AUDIOLOGY CLINIC
715 Clinic Drive, Lyles-Porter Hall
West Lafayette, IN 47907-2122
(765) 494-3789
(765) 494-0771 (fax)

Complete this questionnaire and bring it with you when you visit your physician, physical therapist, or other medical practitioner. You may want to reference your previous medical history records and/or ask a friend or family member familiar with your condition to help you.

Today's Date: _____

Name: _____ **Date of Birth:** _____

I. INITIAL ONSET

Describe what happened the first time you experienced dizzy/imbalanced symptoms:

II. SYMPTOMS

Check all that apply *(In the space after each symptom you check, rate the severity of that symptom using a scale of 0-10, with 10 being most severe.)*

✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10
	Dizziness			Spinning			Lightheadedness			Rocking/tilting	
	Visual changes			Headache			Fatigue			Unsteadiness	
	Falling			Noise in ears			Brain fog			Fainting	
	Hearing loss			Double vision			Fullness, pressure, or pain in ears			Other:	

III. History of Present Illness

a. Describe your current problem:

i. When did your problem start (date)? _____

ii. Was it associated with a related event (e.g. head injury)? ☐ Yes ☐ No
If yes, please explain: _____

iii. Was the onset of your symptoms: ☐ sudden ☐ gradual ☐ overnight ☐ other
(describe): _____

iv. Are your symptoms: ☐ constant ☐ variable (i.e. come and go in spells)

- If variable:
  a. The spells occur every (# of): _____ hours _____ days _____weeks _____ months _____ years.
  b. The spells last: ☐ seconds ☐ minutes ☐ hours ☐ days
  c. Do you have any warning signs that a spell is about to happen? ☐ yes ☐ no
  If yes, please describe: _____
  d. Are you completely free of symptoms between spells? ☐yes ☐no

v. Do your symptoms occur when changing positions? ☐ yes ☐ no

If yes, check all that apply:

√	Position	√	Position
	Rolling your body to the left		Rolling your body to the right
	Moving from a lying to a sitting position		Looking up with your head back
	Turning head side to side while sitting/standing		Bending over with your head down

vi. Is there anything that makes your symptoms better? ☐ yes ☐ no
If yes, please explain: _____

vii. Is there anything that makes your symptoms worse? ☐ yes ☐ no
If yes, check all that apply:

√	Activity / Situation	√	Activity / Situation
	Moving my head		Physical activity or exercise
	Riding or driving in the car		Large crowds or a busy environment
	Loud sounds		Coughing, blowing the nose, or straining
	Standing up		Eating certain foods
	Time of day		Menstrual periods (if applicable)
	Stress		Other:

viii. When you have symptoms, do you need to support yourself to stand or walk?
☐ yes ☐ no
If yes, how do you support yourself? _____

ix. Have you ever fallen as a result of your current problem? ☐ yes ☐ no

x. Do you have a history of:

✓	Diagnosis	✓	Diagnosis	✓	Diagnosis	✓	Diagnosis
	Migraines		Seizures		Tumor		Stroke
	Multiple Sclerosis		Neuropathy		Panic attacks/Anxiety		Congestive heart failure
	Concussion		Depression		Cervical Spine Arthritis		Diabetes Mellitus
	Glaucoma		Macular Degeneration		Parkinson's Disease		Ataxia

xi. Has there been a recent change in your vision, including contacts or glasses?
☐ yes ☐ no Explain: _____

b. Describe any ear related symptoms:

i. Do you have difficulty with hearing? ☐ yes ☐ no
If yes, which ear(s): ☐ left ☐ right ☐ both
When did this start? _____

ii. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms?
☐ yes ☐ no

c. When dizzy or imbalanced, do you experience any of the following:

Symptom	Yes	No
Lightheadedness or a floating sensation?		
Objects or your environment turning around you?		
A sensation that you are turning or spinning while the environment remains stable?		
Nausea or vomiting?		
Tingling in your hands, feet or lips?		

When you are walking, do you: ☐ veer left? ☐ veer right? ☐ remain in a straight path?

d. Prior relevant medical evaluations, diagnostic testing, and treatment:

i. Have you seen other healthcare providers for your current condition? ☐ yes ☐ no
If yes, who: ☐ primary care doctor ☐ENT/HNS doctor ☐ neurologist ☐ cardiologist
☐ Emergency room doctor ☐ Other: _____

ii. Have you had any of the following done for this condition elsewhere?

√	Test/Therapy	When	Where	Results
	ENG/VNG			
	CT Scan or MRI			
	Hearing test			
	Rehabilitation (PT or OT)			Did it help? ☐ yes ☐ no

IV. ADDITIONAL INFORMATION

Is there anything else you would like to make sure to tell your physician about?

OPTIONAL QUESTIONS: The following questions are not necessary to determine a diagnosis, but may be helpful in formulating a treatment plan.

V. SOCIAL HISTORY / LIFESTYLE

a. Please describe your current work status:

☐ full-time ☐ part-time ☐ unemployed ☐ disabled ☐ retired

Occupation (if applicable): _____

b. Please indicate your level of activity currently and prior to developing symptoms:

i. Current activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous

List activities/hobbies: _____

ii. Prior activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous

List activities/hobbies: _____

iii. If your activity is light or inactive, what are the major barriers? (check all that apply)

☐ dizziness ☐ imbalance ☐ fear of falling ☐ lack of energy ☐ other: _____

VI. HABITS

a. Please describe your habits in regards to the following substances:

i. Caffeine

☐ I do not consume caffeine.

☐ I consume caffeine.

I drink _____ (#) cups of _____ (e.g. coffee) per ☐ day ☐ week ☐ month

ii. Tobacco

☐ I do not consume tobacco.

☐ I consume tobacco.

I smoke/chew _____ (#) of _____ (product) per ☐ day ☐ week ☐ month

iii. Alcohol

☐ I do not consume alcohol.

☐ I consume alcohol.

I drink _____ (#) glasses of _____ (e.g. wine) per ☐ day ☐ week ☐ month

iv. Recreational drug use

☐ I do not use drugs.

☐ I use _____.

How many times/day? _____ For how many years? _____

v. Medications

☐ I do not take any medications.

☐ I take the following medications:

1. Meclizine ☐ yes ☐ no
2. Ativan ☐ yes ☐ no
3. Hydrochlorothyazide ☐ yes ☐ no
4. Other: _____
5. Other: _____
6. Other: _____

Special Note: This form is provided as a means to help you gather information on your medical history and current symptoms while you have time and resources to do so completely and accurately, and with assistance, if necessary. Some physicians may have their own intake form they want you to fill out. If so, you may use this form as a reference. If there is information on this form that your physician does not ask you, you may want to bring it to their attention, as it may help them to more accurately diagnose your condition.

PURDUE UNIVERSITY
Department of Speech, Language, and Hearing Sciences

PURDUE UNIVERSITY AUDIOLOGY CLINIC
715 Clinic Drive, Lyles-Porter Hall
West Lafayette, IN 47907-2122
(765) 494-3789
(765) 494-0771 (fax)

Physician Referral Form: Vestibular Testing

Date of Referral:_____ Referring Physician:_____

Patient Name:_____ Date of Birth:_____

Indications for referral:_____

ICD-10/Diagnosis code: _____

Please check the tests that are being ordered below:

☐ **VFT/Vestibular Function Test** – Routine test battery including: VNG, SHA, and VEMP.

If a routine test battery (VFT) is not desired, please select individual test orders below:

☐ **VNG/Videonystagmography** – "gold standard" for identification of vestibular hypofunction.

☐ **SHA/Rotational Chair Test** – test providing supporting information regarding magnitude of vestibular hypofunction, or quality and degree of central nervous system compensation for vestibular hypofunction.

☐ **VEMP/Vestibular Evoked Myogenic Potential** – assessment of otolith organs and vestibular nerve function.

☐ **CDP/Computerized posturography** – provides information regarding ability of central nervous system to accurately integrate visual, somesthetic, and vestibular signals.

☐ **HE/Audiometry** – conventional behavioral hearing evaluation.

☐ **ABR/Neurodiagnostic Auditory Brainstem Response** – objective evaluation of the integrity of the VIIIth nerve and pontine auditory pathways brainstem response to auditory stimuli.

☐ **EcochG/Tympanic Electrocochleography** – assesses whether increased intralabyrinthine pressure is present. Referral must be accompanied by recent audiogram and ear canals must be free of debris for this test.

Physician signature:_____

Office phone:_____ Office fax:_____

A copy of patient instructions is on the reverse of this form.
Test results will be forwarded to referring physician's office via fax

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

Patient Instructions for Vestibular Function Testing

- The standard appointment is scheduled to be 2 hours long.
- If you are already unsteady or dizzy before your appointment, we suggest that you bring someone with you who can drive you home after the testing has been completed.
- Your testing might include: sitting with your head still for 5-10 minutes at a time, an examiner moving your head into various positions for 5-10 minutes at a time, standing for less than 15 minutes at a time, sounds played to your ear via an earphone less than a minute at a time, or water trickled into your ear for less than a minute at a time.
- Since many foods and beverages can affect the results of this test we ask that you do not eat anything 6 hours prior to the appointment. If you are diabetic you may eat a small meal (example: toast and juice) on the morning of your test.
- Please continue to take your prescription medications, however, we ask that you bring with you a list of these medications and their dosages.
- Please do not wear makeup or moisturizer, especially mascara and eye liner because they can affect the results of the tests.
- If you have hearing aids or cochlear implants, please wear them for your appointment.

PURDUE UNIVERSITY AUDIOLOGY CLINIC 715 Clinic Drive, Lyles-Porter Hall West Lafayette, IN 47907-2122 (765) 494-3789 (765) 494-0771 (fax)

DIAGNOSTIC TESTS FOR VESTIBULAR PROBLEMS

VEDA
LIFE REBALANCED

Electro/Video-nystagmomography (ENG/VNG) uses small electrodes over the skin around the eyes or video goggles to record eye movements. Assesses eyes movements while following a moving object, when the head is placed in different positions, and with changes in temperature to the ear (with air or water).

Rotation Tests use video goggles or electrodes which record eye movements as the head is rotated side to side. These include the auto head rotation, computerized rotary chair test, or a general screening test.

Video Head Impulse Test (vHIT) involves a small set of glasses with a camera which records eye movements as the head is moved with small quick movements.

Vestibular Evoked Myogenic Potential (VEMP) evaluates whether certain vestibular organs and associated nerves are intact and functioning normally. Electrodes are attached to the skin near the eyes and neck as sound is played through ear phones, which stimulates the vestibular organs and causes activation or reduction in activity of corresponding muscles.

Computerized Dynamic Posturography (CDP) tests postural stability in different conditions (eyes open/closed, stationary/moving platform, visual surround moving). A patient wears a safety harness and a force plate measures his/her overall sway or movement.

Audiometry (Hearing tests) consists of presenting words and tones at different pitches and levels, measuring the patient's ability to distinguish these tones/words with headphones. Tympanometry and acoustic reflex are common hearing tests.

Otoacoustic Emissions (OAE) provides information about how the hair cells of the cochlea are working when a series of clicks are produced by a tiny speaker inserted into the ear canal. This is often done in infants and young children.

Electrocochleography (ECog) utilizes an earphone which plays sound in the ear and electrodes which measure the response while a patient lies still.

Auditory Brainstem Response Test (ABR) measures how the nervous system responds to sound and is used when patients cannot respond to audiometry testing (infants). This test can sometimes indicate the presence of an acoustic neuroma.

Magnetic Resonance Imaging (MRI) uses a magnetic field and radio waves to produce an image of body tissues. An MRI of the brain can reveal the presence of tumors, stroke damage, or other soft tissue abnormalities.

Computerized Axial Tomography (CAT/CT) is an x-ray technique for assessing the inside of the temporal bone, the area within the skull that the inner ear is located, to identify any abnormalities, such as a fracture or thinning bone.

Other Tests include blood work, allergy tests, and vision tests to rule out causes of imbalance that are unrelated to the vestibular system.