Interview Sheet (Vertigo, Dizziness)

IDNo:

Written on year month day

Name		Sex	male ・ female	Weight	kg
Address	Zip code 〒 -	Birth Date	y m d		
		Tel	( ) —		
		Cellular Phone	( ) —		

① How is your vertigo or dizziness?

1）sense of rotation 2）floating sense 3）dizziness 4）darkness of vision 5）loss of consciousness
6）anxiety of falling 7）others（ ）

② When did your vertigo or dizziness occur?

days ago ・ weeks ago ・ months ago ・ month day ・ hard to define

③ Do you suspect anything to be the trigger of your vertigo or dizziness?

1）nothing (occurred suddenly) 2）head movement（ upward ・ downward ・ sideway ・ look back ）
3）when lying with your head (right side, left side)down、turn over in bed 4）suddenly stand up
5）others（ ）

④ Does your vertigo or dizziness repeat?

1）only once 2）more than twice（ frequency times/ day ・ week ・ month ・ year ）
3）continuing（getting better ・ unchanged ・ worse ）

⑤ How long does your vertigo or dizziness last?

1）a few seconds 2）a few minutes 3）tens of minutes 4）hours 5）one day 6）a few days
7）still lasting 8）others（ ）

⑥ During or around your vertigo or dizziness did you have any symptoms below?

A 1）hard to hear (right ,left) 2）ear ringing (right , left)
3）stuffiness in the ear(right , left) 4）rumbling or echoing in the ear（ right 、 left)

B 1）headache 2）could not move hand,foot,or other organ 3）could not speak
4）difficulty of swallowing 5）double vision 6）numbness of face, hand, foot, or other organ
7）lost consciousness 8）convulsion, or cramp

C 1）felt sick 2）threw up 3）cold sweat 4）palpitation, throbbing

⑦ Please tell us what you are worried about or your request for the therapy.

（ ）

⑧ Are you taking any drug or any therapy elsewhere?

（ ）

⑨ How did you find out our clinic? If you do not mind please let us know.

1）heard of us from your family or relatives 2）from your friend（Mr. or Ms. ）
3）consultation from other clinic （ clinic or hospital ） 4）Homepage
5）signboard of entrance6）signboards in railway stations 7）neighborhood 8）telephone directory
9）others （ ）