HOUSE CLINIC

Date From: _____ To: _____

VESTIBULAR SYMPTOMS LOG

(Instructions: Rate severity of symptoms on a scale from 1 to 10 with 10 being the worst. Leave symptoms you don't have as BLANK.)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Spinning							
Rocking							
Lightheaded							
Imbalance							
Hearing Change							
Sound Sensitive							
Ear Ringing							
Ear Fullness							
Ear Pain							
Headache							
Neck pain							
Nausea							
Light Sensitive							
Visual problem							
Brain fog							
COMMENTS: (include things such as how long symptom lasted, possible triggers, dietary changes, medications added, physical therapy sessions)							

Extra copies can be obtained at www.houseclinic.com/balance