Name: ______________________________ Date:__________

Do you have a history of ADHD/ADD? Circle Yes or No
Do you have a history of Anxiety? Circle Yes or No
Do you have a history of migraine? Circle Yes or No
Do any of your family members have a history of migraine? Circle Yes or No
Do you have a history of motion sickness? Circle Yes or No
Do you feel dizzy, nauseated, anxious or foggy in busy environments now? Circle any that apply
Do you feel dizzy or nauseated if you move your head quickly or move quickly? Circle Yes or No
Do you have pressure or pain around your eyes when you read? Circle Yes or No

How have you been feeling recently? Please check the appropriate column

Symptom	**0** Not at all	**1** Slight	**2** Mild	**3** Mild to Moderate	**4** Moderate	**5** Severe	**6** Extreme
Headache							
Nausea							
Vomiting							
Balance problems							
Dizziness							
Double vision/blurry vision							
Fatigue							
Sleep problems							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervousness							
Feeling more emotional							
Feeling slowed down							
Feeling mentally foggy							
Difficulty concentrating							
Difficulty with memory							
Neck pain or stiffness							
Numbness/tingling							