**ESSEX DIZZINESS AND BALANCE REHABILITATION CLINIC**

**APPLICATION FORM FOR VESTIBULAR SUPPORT GROUP**

**BALANCED VIEW**

|  |  |
| --- | --- |
| **PLEASE ANSWER ALL QUESTIONS** | **Yes/No** |
|  |  |
| **I would like to meet fellow sufferers from Vestibular Disorders** |  |
| **I have attended Vestibular Rehabilitation in the past** |  |
| **I still suffer signs and symptoms of a Vestibular Disorder** |  |
| **I have been given a diagnosis** |  |

|  |  |
| --- | --- |
| **Please state you diagnosis:** |  |
| **Name:** |  |
| **Address:** |  |
| **Home Telephone:** |  |
| **Mobile Telephone:** |  |
| **Email:** |  |

**We will be holding monthly meetings (at small cost of £5.00) with a lecturer presenting certain Vestibular conditions. Teas and coffees will be supplied and you will be encouraged to meet fellow sufferers and exchange contact details. You will be added to our database and informed of the upcoming meetings.**

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**