Vestibular/Imbalance Intake Form

COOPERATIVE PERFORMANCE & REHABILITATION

Name:_____ **Date:**_____

Occupation:_____ Full-time ◻ Part-time ◻ Other ◻ Date of Onset:_____

Primary Concern:

Describe the problem that brings you to therapy: _____

_____

_____

_____

_____

_____

Since then, has your problem: Worsened ◻ Improved ◻ Same ◻

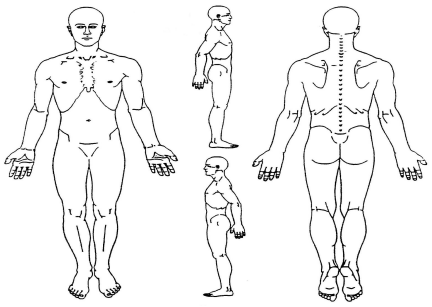
Have you experienced a recent trauma? No ◻ Yes ◻ If yes describe _____

Have you ever experienced this problem before? No ◻ Yes ◻ If yes, please describe:_____

_____

PAIN: If you have no pain, please mark as 0.

If you are having pain, please rate the severity on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:											
At Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At Best	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Current	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**



Symptoms: **Please indicate the location of your symptoms**

Symptom Description (circle all that apply):

Spinning	Rocking/Swaying	Nausea/Vomitting	Balance difficulty
Light Headedness	Ringing in ears	Hearing loss	Ear fullness/ pressure
Headaches	Decreased concentration	Short term memory loss	Long term memory loss
Light sensitivity	Double vision	Objects appear distorted	Sensitivity to moving backgrounds
Disorientation	Neck pain	Back pain	Facial numbness
Passing out/ fainting	Fatigue	Weakness	Other:

Symptoms increase with (circle all that apply):

Sit to stand	Turn head	Walking	Bending/ Squatting	Reading	Rolling in bed
Lying to sit	Look up/down	Crowds	Cough/ Sneeze	Driving	Bearing down/ straining

Other (please list): _____

Medical History:

Circle all that Apply:

Osteoporosis	Surgical History	Seizure/ Epilepsy	Anemia	Hernia
Arthritis	Previous Therapy	Numbness/ Tingling	Headaches	Anxiety
Diabetes 1 or 2	Cardiovascular Disease	Head Injury/ Concussion	Thyroid Problems	Asthma
Cancer	Fibromyalgia	Shortness of Breath	Depression	Other

History of falls? No ▫ Yes ▫ If yes how often?_____ When was last fall?_____

Please Describe any circled items:_____

_____

Surgical History (type/date):_____

Current Medications:

Prescriptions ▫ Vitamins ▫

Over the Counter ▫ Herbals ▫ See med list in eDocs ▫

List of Medications:_____

Imaging:

(X-Ray, MRI, EMG, etc):

_____

_____

BMI: Height (inches)**:**_____ **Weight** (lbs)**:**_____

_____ _____

Patient/Guardian Signature **Date**

Dizziness Handicap Inventory

Part 1 Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others?	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	No	Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	Yes	No	Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	No	Sometimes
P17. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes
F19. Because of your problem, is it difficult for you walk around the house in the dark?	Yes	No	Sometimes

E20. Because of your problem, are you afraid to stay home alone?	Yes	No	Sometimes
E21. Because of your problem, do you feel handicapped?	Yes	No	Sometimes
E22. Has your problem placed stress on your relationships with members of your family or friends?	Yes	No	Sometimes
E23. Because of your problem, are you depressed?	Yes	No	Sometimes
F24. Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
P25. Does bending over increase your problem?	Yes	No	Sometimes

Part 2 Instructions: Put a check in the box that best describes you.

- ☐ Negligible symptoms (0)
- ☐ Bothersome symptoms (1)
- ☐ Performs usual work duties but symptoms interfere with outside activities (2)
- ☐ Symptoms disrupt performance of both usual work duties and outside activities (3)
- ☐ Currently on medical leave or had to change jobs because of symptoms (4)
- ☐ Unable to work for over one year or established permanent disability with compensation payments (5)