Vestibular Intake Form

Orthopedic Physical Therapy, Inc.

Name:_____ **Date:**_____

Occupation:_____ Full-time ❑ Part-time ❑ Other ❑

Primary Concern:
History of falls? No ❑ Yes ❑ If yes how often?_____ When was last fall?_____
Describe the problem that brings you to therapy: _____
_____
Date problem began:_____ 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:_____
_____

Symptoms:
Symptom Description (circle all that apply):

Light Headedness	Visual Disturbances	Disorientation	Hearing loss
Headaches	Rocking/ Swaying	Difficulty with Memory	Ringing in ears
Nausea	Spinning	Facial Numbness	Ear fullness/ pressure
Passing out/ Fainting	Balance Difficulty	Fatigue/ weakness	Other:_____

How often do symptoms occur? Daily ❑ Weekly ❑ Constantly ❑
How long do symptoms last? Seconds ❑ Minutes ❑ Hours ❑ Days ❑

Symptoms increase with (circle all that apply):

Rolling in bed	Turn head	Walking	Bearing down/ Straining	Reading
Lying to sit	Look up/Down	Crowds	Lying down	Loud Noises
Sit to stand	Bending/ Squatting	Driving	Cough/ Sneeze	Other

Medical History:
Circle all that Apply:

Osteoporosis	Previous Therapy	Seizure/ Epilepsy	Anemia
Cardiovascular Disease	Arthritis	Numbness/ Tingling	Asthma
Diabetes 1	Anxiety	Head Injury/ Concussion	Shortness of Breath
Diabetes 2	Depression	Thyroid Problems	Other

Describe any items that are circled:_____
Surgical history (type/date): _____

Current Medications:
Prescriptions ❑ Vitamins ❑
Over the Counter ❑ Herbals ❑
List of Medications:_____
_____

Imaging:
(X-Ray, MRI, EMG, CT scan etc):
_____
_____

_____ _____
Patient/Guardian Signature **Date**

In the last WEEK what percentage of the time has dizziness interfered with your activities? Mark on line below.

[----------]
0% 25% 50% 75% 100%

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)