BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

PATIENT INFORMATION

NAME	SEX ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH
ADDRESS			
CITY	STATE	ZIP CODE	
BILLING ADDRESS (if different from above)			

PHONE Please check the number you prefer to be called at	REFERRED BY:
☐ HOME ( ) ______	☐ DOCTOR ______
☐ CELL ( ) ______	☐ FRIEND ______
☐ WORK ( ) ______	☐ OTHER ______

EMAIL
☐ I prefer appointment reminders be sent to my email

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT	
ADDRESS		
CITY	STATE	ZIP CODE
PHONE ( )	ALTERNATE ( )	

WORKERS COMPENSATION / ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO	WERE YOU INJURED ON THE JOB ☐ YES ☐ NO	DATE OF INJURY/ACCIDENT	CLAIM NUMBER
NAME OF INSURANCE CARRIER		PHONE ( )	FAX ( )
CLAIMS ADJUSTER		PHONE ( )	FAX ( )
NURSE CASE MANAGER		PHONE ( )	FAX ( )

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

CONSENT FOR TREATMENT
I hereby authorize my consent to be treated now and in the future by Balance Rehabilitation.

PATIENT / INSURED SIGNATURE	DATE

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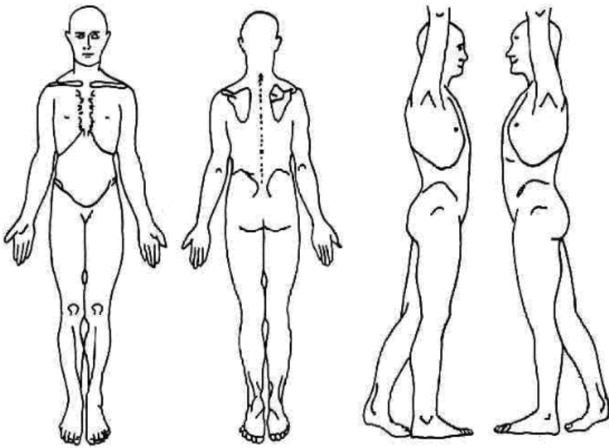
Vestibular Patient History

Name:			Date:	
Date of Birth:	Age:	Height:	Weight:	Next Doctors Visit:
Occupation:			Have you been a patient here before?	

What brings you to physical therapy?	
Current Problem/Symptoms	When did the problem start?
1.	
2.	
How often do you experience you symptoms? (please circle one) *0-25% intermittently* *26-50% occasionally* *51-75% frequently* *76-100% constantly*	
Are your symptoms changing? (please circle one) *improving* *not changing* *getting worse*	

I currently am not experiencing any pain. True ☐ (skip to next page) False ☐ (please fill out below)



Pain increases during the following activities	
1)	3)
2)	4)

What is the nature of your symptoms?	
Circle all that apply Numbness / Tingling Shooting Burning Throbbing Sharp Dull/Achy Weakness Constant Intermittent Worse in AM, PM, at night	
What is the intensity level of your SYMPTOMS ?	
At Worst	0 1 2 3 4 5 6 7 8 9 10 (None / Moderate / Severe)
Current	0 1 2 3 4 5 6 7 8 9 10 (None / Moderate / Severe)
At Best	0 1 2 3 4 5 6 7 8 9 10 (None / Moderate / Severe)

Pain decreases during the following activities	
1)	3)
2)	4)

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Name:	Date:

Please list your goals in coming to physical therapy.

Please indicate if you have had or have any of the following conditions.					
Condition	Yes	No	Condition	Yes	No
History of Cancer			Pacemaker		
Heart disease			Diabetes I or II		
High/Low blood pressure			Allergies/Asthma		
Angina / Chest pain			Memory Loss		
Shortness of breath			Headaches / Migraines		
Stroke / TIA			Hernia		
Osteoporosis			Nausea or vomiting		
Osteoarthritis			Bowel or bladder problems		
Rheumatoid arthritis			HIV - positive / AIDS/Hepatitis		
Joint replacement			Dementia/Alzheimer's Disease		
Recent excessive weight loss			Pregnant (currently)		
Changes in appetite			Seizures		
Lightheadedness/Dizziness			Fainting		
Frequent loss of balance			Difficulty sleeping		
Falls			Smoking tobacco		
Anxiety / Stress			Vision (glasses / contacts)		
Depression			Hard of hearing / hearing aid		
Fibromyalgia			Lupus		
Obesity			Parkinson's/Huntington's		
TBI/History of Concussions			Alcoholism		

Please list any other medical conditions, surgeries, or health concerns not listed above.	
Condition/Surgery	Date

Which diagnostic tests have you had? (please circle all that apply)

X-Ray MRI CT scan VNG Blood Work PET scan EMG EEG Other:

Name:	Date:

*****Skip the section below and questions 1-17 if you do not have dizziness*****

If your problem is dizziness, describe what you mean by "dizzy." (please circle all that apply)

Lightheaded *Spinning* *Dizziness occurs in attacks* *Pressure in the head*
Off balance *Sensation that you are turning/spinning* *Sensation that things are turning around you*
Headache *Nausea or vomiting* *Rocking sensation* *Other:*

*If you have **dizzy spells**:*

1. When did the dizziness first occur?
2. Is your dizziness constant?
3. Does it come in attacks? ❑ Yes ❑ No
   If yes, how often do the attacks occur? ______________________________
   How long do the attacks last? ❑ seconds ❑ minutes ❑ hours ❑ days ❑ weeks
   Are there symptoms between attacks? ❑ Yes ❑ No
4. Does the dizziness occur only in certain positions? ❑ Yes ❑ No
   If yes, ❑ lying down ❑ sitting up ❑ head movements: up / down / right / left ❑ rolling: right / left
5. What makes your symptoms better?
6. What makes your symptoms worse?
7. Have you ever injured your head? ❑ Yes ❑ No
8. Have you had any intravenous antibiotics or chemotherapy? ❑ Yes ❑ No
9. Do you suffer easily from motion sickness? ❑ Yes ❑ No
10. Do you experience migraines? ❑ Yes ❑ No
11. Do you have neck discomfort or injury? ❑ Yes ❑ No
12. Do you have problems with your vision? ❑ Yes ❑ No
13. Do you have dizziness when exposed to loud noises? ❑ Yes ❑ No
14. Do you have dizziness when exercising or straining? ❑ Yes ❑ No
15. Do you have dizziness when sneezing or laughing? ❑ Yes ❑ No
16. Do you have difficulty in any of these activities? ❑ Yes ❑ No
    ❑ riding/driving a car ❑ malls / crowds / movies
17. Have you had allergy testing? ❑ Yes ❑ No
    If yes, what were the findings?

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Name:	Date:

Do you have any problems with the following?		
Yes	No	
		Have you fallen?
		If yes, have you had 2 or more falls in the past year?
		If yes, have you had any fall with injury in the past year?
		Impaired vision
		Double vision
		Blurred vision
		Objects move up and down / side to side when walking or running
		Flashes of light
		Trouble reading
		Have you had previous problems with your ears?
		Difficulty hearing
		Ear pain
		Drainage from ears
		Does your hearing fluctuate or worsen with dizzy episodes?
		Ringing in the ears or head noise (if so, which ear? ❑ Right ❑ Left)
		Fullness or pressure in the ears (if so, which ear? ❑ Right ❑ Left)
		Facial weakness
		Facial numbness
		Headache or migraine (circle)

List all doctors you would like to receive a copy of your physical therapy evaluation.		
MD Name	Address/Phone/Fax	Specialty
Referring MD		
Primary Care MD		
Other MD		

I certify that the foregoing statements are true to the best of my knowledge and belief.	
Signature of Patient	Date
Reviewed by Physical Therapist	Date

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Medication List

Patient Name: ______________________________ Date: ________________

Please list your current medications (including over-the-counter, vitamins, herbal, and dietary supplements).

❑ See attached list

Name	Dosage	Frequency	Administration Route (ex: oral, injection, etc.)	What condition is this for?

Date	Modifications	No Changes	Reviewing Physical Therapist

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Dizziness Handicap Inventory

Patient Name: ______________________________ Date: ________________

Please check "Yes", "Sometimes", or "No" to each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.	Yes	Some-times	No
1. Does looking up increase your problem?			
2. Because of your problem, do you feel frustrated?			
3. Because of your problem, do you restrict your travel for business or recreation?			
4. Does walking down the aisle of a supermarket increase your problem?			
5. Because of your problem, do you have difficulty getting into or out of bed?			
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?			
7. Because of your problem, do you have difficulty reading?			
8. Does performing more ambitious activities like sports or dancing or household chores such as sweeping or putting the dishes away increase the problem?			
9. Because of your problem, are you afraid of leaving your home without someone accompanying you?			
10. Because of your problem, are you embarrassed in front of others?			
11. Do quick movements of your head increase your problem?			
12. Because of your problem, do you avoid heights?			
13. Does turning over in bed increase your problem?			
14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?			
15. Because of your problem, are you afraid people may think you are intoxicated?			
16. Because of your problem, is it difficult for you to go for a walk by yourself?			
17. Does walking down a sidewalk increase your problem?			
18. Because of your problem, is it difficult for you to concentrate?			
19. Because of your problem, is it difficult for you to walk around your house in the dark?			
20. Because of your problem, are you afraid to stay at home?			
21. Because of your problem, do you feel handicapped?			
22. Has your problem placed stress on your relationships with your family or friends?			
23. Because of your problem, are you depressed?			
24. Does your problem interfere with your job or household responsibilities?			
25. Does bending over increase your problem?			

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

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