Vestibular Intake Form

***Are you currently having any home health services? Yes No

Section I: Name _____ Age ____ Today's date _____

Please circle the symptom(s)/problem(s) that bring you to therapy: *Dizziness* *Lightheadedness* *Falls*

Headache *Double vision* *Vertigo/spinning* *Weakness* *Memory Loss* *Decreased Balance*

Hearing loss (new) *Ringing in ears* *Difficulty focusing* *Vision changes* _____ *(describe)*

Sensitivity to sound/light *Other*_____

Date problem began: _____ Are you: *Improving* *Worsening* *No change*

Please describe how the symptoms began: _____

_____

What has been your worst event/situation? _____

Is this your first episode? If no, please describe _____

What are your goals for treatment? _____

Do you currently have pain? No Yes Where?_____ Pain Rating: ___/10 (10 worst)

Section II:

Are (or were) you taking any meds specifically for this problem? No Yes, please list_____

_____

Have you had any tests for this problem? Ex: (MRI, heart tests, MABI, cat scan) _____

Have you had a recent respiratory or sinus infection? Yes No

Is the problem you are here for today affecting your activity level, ability to work or your participation in school?
No Yes How? _____

Section III: <u>IF YOU ARE HERE FOR DIZZINESS, LIGHTHEADEDNESS OR VERTIGO, PLEASE ANSWER THE FOLLOWING. IF NOT, SKIP THIS SECTION AND CONTINUE ON THE BACK OF THIS PAGE</u>.

Are your symptoms? (circle all that apply) *Constant* *Come and Go* *Provoked by movement*

How long do your symptoms last when provoked: *Seconds* *Minutes* *Hours* *Weeks* *Constant*

What causes or worsens the symptoms? (Example: looking up) _____

_____

What makes it better? (Ex. Sit still) _____

_____

➔➔➔ OVER ➔➔➔

Please put a check (✓) next to the response to each question that applies to you and your dizziness.

		YES	SOMETIMES	NEVER
P1.	Does looking up make your problem worse?			
E2.	Because of your problem, do you feel frustrated?			
F3.	Because of your problem, do you restrict your travel for business or recreation?			
P4.	Does walking down the aisle of a supermarket make your problem worse?			
F5.	Because of your problem, do you have difficulty getting into or out of bed?			
F6.	Does your problem significantly restrict your participation in social activities such as going to movies, dinner, dancing, parties, etc.?			
F7.	Because of your problem, do you have difficulty reading?			
P8.	Does doing more ambitious activities like sports, dancing, household chores such as sweeping, putting dishes away, etc., make your problem worse?			
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?			
E10.	Because of your problem, have you been embarrassed in front of others?			
P11.	Do quick movements of your head increase your problem?			
F12.	Because of your problem, do you avoid heights?			
P13.	Does turning over in bed make your problem worse?			
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
E15.	Because of your problem, are you afraid people may think you are intoxicated?			
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17.	Does walking down a sidewalk make your problem worse?			
E18.	Because of your problem, is it difficult for you to concentrate?			
F19.	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20.	Because of your problem, are you afraid to stay home alone?			
E21.	Because of your problem, do you feel handicapped?			
E22.	Has your problem placed stress on your relationships with members of your family or friends?			
E23.	Because of your problem, are you depressed?			
F24.	Does your problem interfere with your job or household responsibilities?			
P25.	Does bending over make your problem worse?			

"Dizziness Handicap Index" Jacobson, Newman; Arch Otolaryngol Head Neck Surg; 116:424, 1990 →→→ OVER →→→

Olathe Medical Center
20333 West 151st Street
Olathe, Kansas 66061

PLACE PATIENT LABEL HERE

Past medical history: Do you have ANY previous history of the conditions listed below?

Condition:	yes	no	**Condition:**	Yes	no
High or Low blood pressure			Migraines		
Heart condition			ADD/ADHD		
Diabetes			Anxiety		
Blood clots			Depression		
Seizures			Currently pregnant		
Cancer					
Shortness of breath					

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year? ❑ YES ❑ NO If yes, please describe: _____

_____

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
Preferred method of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Video ❑ Other: _____

In the space below, please tell us anything else you think your therapist will need to know _____

_____

Staff Initials	**Date**	**Time**	**ALLERGIES** **Do you have any allergies?**

Staff Initials	**Date**	**Time**	**OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS** **Do you have any other diagnoses &/or significant conditions? No Yes, please list:**

Staff Initials	**Date**	**Time**	**PREVIOUS PROCEDURES/SURGERIES** **Do you have any previous procedures or surgeries?**

Staff Initials	**Date**	**Time**	**CURRENT MEDICATIONS** **See attached list of medications that the patient provided.** **Are you currently taking any medications, including herbals? No Yes, please list:**

INITIALS	**STAFF SIGNATURE**	**INITIALS**	**STAFF SIGNATURE**

TIME:_____ DATE: _____ PATIENT SIGNATURE: _____

PHYSICAL THERAPY
VESTIBULAR REHABILITATION
INTAKE QUESTIONNAIRE
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3/2/2020; Rehab

O.M.C. No. 1398

PLACE
PATIENT LABEL
HERE