# VESTIBULAR/CONCUSSION REHABILITATION INTAKE SUMMARY

Name:________________________ Date of Birth:__________ Today's Date:__________

Describe the problem that brings you to therapy: ________________________

Date problem began: ________________________

What is your goal for therapy? ________________________

Do you have pain? ❑ No ❑ Yes, please describe ________________________

**How would you describe your dizziness?**

| | | | | | |
|---|---|---|---|---|---|
| The room is spinning | ❑ No | ❑ Yes | General sense of imbalance | ❑ No | ❑ Yes |
| A "whirling sensation" in my head | ❑ No | ❑ Yes | Lightheadedness | ❑ No | ❑ Yes |

How long do your symptoms last? _____ seconds

_____ minutes

_____ hours

_____ days

**Have you had any of the following symptoms in association with your dizziness?**

| | | | | | |
|---|---|---|---|---|---|
| Hearing loss | ❑ No | ❑ Yes | Vision changes | ❑ No | ❑ Yes |
| Ringing in ears | ❑ No | ❑ Yes | Headaches | ❑ No | ❑ Yes |
| Abnormal sensations of tingling in face/head | ❑ No | ❑ Yes | Loss of consciousness | ❑ No | ❑ Yes |
| Weakness/Numbness of extremities | ❑ No | ❑ Yes | Drop attack | ❑ No | ❑ Yes |

Have you had any tests recently? (X-Ray, MRI, CT Scan, ENG, VEMP, etc.)________________________

________________________

Describe what you do to keep physically fit:________________________

Do you live with: ❑ Spouse ❑ Child(ren) ❑ Parent(s)/Guardian ❑ Alone ❑ Other: __________

Are you currently working? ❑ No ❑ Yes, occupation: ________________________

Is there anything else you think your therapist will need to know?: ________________________

**Past Medical History: Do you have any previous history of the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure: | ❑ No | ❑ Yes | Severe Emotional Disturbance: | ❑ No | ❑ Yes |
| Heart Condition/Pacemaker: | ❑ No | ❑ Yes | Persistent Night Pain: | ❑ No | ❑ Yes |
| Strokes: | ❑ No | ❑ Yes | Cancer: | ❑ No | ❑ Yes |
| Diabetes: | ❑ No | ❑ Yes | Respiratory Disorders/Short of breath: | ❑ No | ❑ Yes |
| Broken Bones (Fractures): | ❑ No | ❑ Yes | Excessive Fatigue: | ❑ No | ❑ Yes |
| Metal Implants: | ❑ No | ❑ Yes | Frequent/Severe Headaches: | ❑ No | ❑ Yes |
| Arthritis: | ❑ No | ❑ Yes | Unexplained Weight Loss/Gain: | ❑ No | ❑ Yes |
| Fibromyalgia: | ❑ No | ❑ Yes | Change in Bowel/Bladder Function: | ❑ No | ❑ Yes |
| Seizures: | ❑ No | ❑ Yes | Any communicable disease: | ❑ No | ❑ Yes |

Are you pregnant now or is there a chance you could be? ❑ No ❑ Yes

Have you taken steroids for a prolonged period of time? ❑ No ❑ Yes

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# VESTIBULAR/CONCUSSION REHABILITATION INTAKE SUMMARY

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other ____________________
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other __________

Preferred Mode of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Other__________________________

| **ALLERGIES**<br>Do you have any allergies? ❑ No ❑ Yes, please list: | **REACTION** |
|---|---|
| | |
| | |
| | |
| | |

| **OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS**<br>Do you have any other diagnoses or significant conditions? ❑ No ❑ Yes, please list: | **Staff Use Only** | | |
|---|---|---|---|
| | **Time** | **Date** | **Signature** |
| | | | |
| | | | |
| | | | |
| | | | |

| **PREVIOUS PROCEDURES / SURGERIES**<br>Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list: | **Staff Use Only** | | |
|---|---|---|---|
| | **Time** | **Date** | **Signature** |
| | | | |
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| **CURRENT MEDICATIONS, INCLUDING HERBALS**<br>Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list: | **Staff Use Only** | | |
|---|---|---|---|
| | **Time** | **Date** | **Signature** |
| ❑ See attached list | | | |
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Do you identify with another gender? ❑ No ❑ Yes, which gender do you identify with? ______________________

*Physical Therapy Patients Only: If I am being evaluated by a Physical Therapist without a physician referral, I understand that any diagnosis made is a therapy diagnosis and not a medical diagnosis.*

I acknowledge that the above is true to the best of my knowledge and am aware that if I miss three scheduled visits within the course of treatment that my treatment may be discontinued per therapist discretion.

| ______________ | ______________ | ________________________________________ |
|---|---|---|
| Time | Date | Patient Signature |