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

☐ HOME ( ) _____

☐ CELL ( ) _____

☐ WORK ( ) _____

REFERRED BY:

☐ DOCTOR _____

☐ FRIEND _____

☐ OTHER _____

EMAIL ☐ I prefer appointment reminders be sent to my email

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

EMERGENCY CONTACT INFORMATION

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE

FINANCIALLY RESPONSIBLE PARTY
(IF OTHER THAN PATIENT)

NAME

DOB RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE

IS THE CONDITION WE ARE SEEING YOU FOR RELATED TO:

IS CONDITION SURGERY RELATED? ☐ YES ☐ NO	DATE OF SURGERY:	SURGICAL PROCEDURE:
IS CONDITION MVA RELATED? ☐ YES ☐ NO	DATE OF AUTO ACCIDENT:	DESCRIBE ACCIDENT/INJURY/ILLNESS:
IS CONDITION WORK COMP. RELATED? ☐ YES ☐ NO	DATE OF INJURY:	ARE YOU CURRENTLY WORKING? ☐ YES ☐ FULL-TIME ☐ PART-TIME ☐ NO

NAME OF EMPLOYER AT TIME OF INJURY: CITY STATE ZIP CODE

IS LITIGATION (LAWSUIT) INVOLVED? ☐ YES ☐ NO	NAME OF ATTORNEY:	PHONE #

Are you currently or have you recently received ANY healthcare services through a Home Health Agency (HHA)?

☐ Yes ☐ No **If yes, please provide the following information:**

Name of Home Health Agency: _____

Phone: _____ Date of discharge from Home Health Agency: _____

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: _____ Height: _____ Weight: _____

Occupation: _____

Date of injury, onset of symptoms, or surgery: _____

Please list any conditions that you would like to address with the Physical Therapist and how often you experience them:

_____

_____

Please list your goals in coming to physical therapy:

_____

_____

List any providers you have seen (name & specialty) or treatments you have had for the above conditions:

_____

_____

List any testing (labs, MRI, CT, VNG) you have had for the above condition:

_____

What is the intensity 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

Worse in: Morning Afternoon Night

What is the nature of your symptoms? (Circle all that apply)

Numbness Tingling Shooting Burning

Throbbing Sharp Dull Achy Weakness

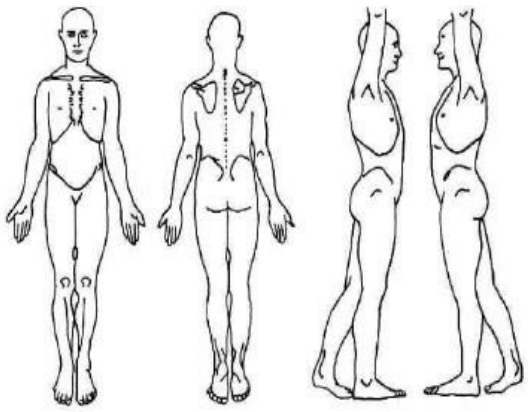
Constant Intermittent

If you are experiencing pain:
Pain increases during:

_____

Pain decreases during:

_____



Please indicate where your pain is located

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Name: _____ **Date:** _____

Please Indicate if you have or have had any of the following conditions: (Check all that apply)

☐Alcoholism
☐Allergies/Asthma
☐Angina/Chest Pain
☐Anxiety/Stress
☐Bowel or Bladder Problems
☐Changes in Appetite
☐Dementia/Alzheimer's Disease
☐Depression
☐Diabetes (I or II)
☐Difficulty Sleeping
☐Fainting
☐Falls
☐Fibromyalgia
☐Frequent Loss of Balance
☐Hard of Hearing/Hearing Aid
☐Headaches/Migraines
☐Heart Disease
☐Hernia
☐High/Low Blood Pressure
☐History of Cancer
☐HIV Positive/AIDS/Hepatitis
☐Joint Replacement
☐Lightheadedness/Dizziness
☐Lupus
☐Memory Loss
☐Nausea/Vomiting
☐Obesity
☐Osteoarthritis
☐Osteoporosis
☐Pacemaker
☐Parkinson's/Huntington's
☐Pregnant (Currently)
☐Recent Excessive Weight Loss
☐Rheumatoid Arthritis
☐Seizures
☐Shortness of Breath
☐Smoking Tobacco
☐Stroke/TIA
☐TBI/History of Concussions
☐Vision (Glasses or Contacts

Please List any other medical conditions, surgeries, or health concerns not listed above:

_____

_____

_____

Have you fallen? Yes / No

If yes, have you had 2 or more falls in the last year? Yes / No

If yes, have you had any fall with injury in the last year? Yes / No

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Name: _____ **Date:** _____

Please circle any of the symptoms you may be experiencing

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: _____

When did the dizziness first occur?	
Is your dizziness constant?	☐ Yes ☐ No
Does it come in attacks?	☐ Yes (How often: _____) ☐ No
How long do the attacks last ?	☐ seconds ☐ minutes ☐ hours ☐ days ☐ weeks
Are there symptoms between attacks?	☐ Yes ☐ No
Does the dizziness occur only in certain positions?	☐ Yes ☐ No
If yes:	☐ lying down ☐ sitting up ☐ rolling: right / left ☐ head movements: up / down / right / left
Do you have dizziness when exposed to loud noises?	☐ Yes ☐ No
Do you have dizziness when exercising or straining?	☐ Yes ☐ No
Do you have dizziness when sneezing or laughing?	☐ Yes ☐ No
What makes your symptoms better?	
What Makes your symptoms worse?	
Have you ever injured your head?	☐ Yes ☐ No
Have you had any IV antibiotics or chemotherapy?	☐ Yes ☐ No
Do you suffer from?	☐ Motion sickness ☐ Migraine
Do you have neck discomfort or injury?	☐ Yes ☐ No
Do you have problems with your vision?	☐ Yes ☐ No
Do you have difficulty when:	☐ riding/driving a car ☐ malls / crowds / movies
Have you had allergy testing?	☐ Yes (Results:_____) ☐ No
Have you had illnesses, hospitalizations, or vaccinations within 6-8 weeks of symptom onset?	☐ Yes ☐ No

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Name: _____ **Date:** _____

Do you have problems with any of the following?

Yes	No	
		Impaired vision
		Double vision
		Blurred vision
		Objects move up and down / side to side when walking or running
		Flashes of light
		Trouble reading
		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)

Is there anything else you would like the physical therapist to know?

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Physical Therapist Date

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Medication List

Name: _____ **Date:** _____

☐ **See Attached**

Medication Name	What condition is it for?

Have there been any recent changes in your medication? Yes / No

If so, please list:_____

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Activities-Specific Balance Confidence Scale

Patient Name: _____ Date: _____

Instructions: For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

(not confident) **0 10 20 30 40 50 60 70 80 90 100** (completely confident)

How confident are you that you will **not** lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tiptoes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding parcels that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

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The Dizziness Symptom Profile

Patient Name: _____ Date: _____

The following pages contain statements with which you can agree or disagree. To what extent do you personally agree or disagree with these statements in regards to your dizziness? Use the following scale:

0 = Strongly Disagree, 1 = Disagree, 2 = Not Sure, 3 = Agree, 4 = Strongly Agree

	Disagree		Not Sure		Agree
1. My dizziness is intense but only lasts for seconds to minutes.	0	1	2	3	4
2. I have had a single severe spell of spinning dizziness that lasted days or weeks.	0	1	2	3	4
3. I have spells where I get dizzy and also have irregular heartbeats (palpitations).	0	1	2	3	4
4. I hear my voice more loudly in one ear compared to the other.	0	1	2	3	4
5. I am unsure of my footing when I walk outside.	0	1	2	3	4
6. I get dizzy when I turn over in bed.	0	1	2	3	4
7. I get dizzy when I am in open spaces and have nothing to hold onto.	0	1	2	3	4
8. I have a roaring sound in one ear only before or during a dizziness attacked.	0	1	2	3	4
9. I am depressed much of the time.	0	1	2	3	4
10. I lost hearing in one ear after an attack of spinning dizziness.	0	1	2	3	4
11. I had a big dizzy spell that lasted for days where I could not walk without falling over.	0	1	2	3	4
12. I get dizzy when I sneeze.	0	1	2	3	4
13. There are times when I get dizzy and also have a headache.	0	1	2	3	4
14. I get dizzy when I strain to lift something heavy.	0	1	2	3	4
15. I get short-lasting, spinning dizziness that happens when I bend down to pick something up.	0	1	2	3	4
16. My hearing gets worse in one ear before or during a dizziness attack.	0	1	2	3	4
17. I had a single constant spell of spinning dizziness that lasted longer than 2 – 3 days.	0	1	2	3	4
18. When I get a headache, I am very sensitive to sound (I try to find a quiet place to rest).	0	1	2	3	4
19. I get short-lasting, spinning dizziness that happens when I go from sitting to lying down.	0	1	2	3	4
20. I can trigger a dizzy spell by placing my head in a certain position.	0	1	2	3	4
21. I had a spell of spinning dizziness that lasted for days or weeks after I had a cold or flu.	0	1	2	3	4
22. I have a feeling of fullness or pressure in one ear before or during a dizziness attack.	0	1	2	3	4
23. I get headaches that hurt so badly that I am completely unable to do my daily activities.	0	1	2	3	4
24. I have spells where I get dizzy and it is difficult for me to breathe.	0	1	2	3	4
25. I have a sensation of dizziness or imbalance daily or almost daily.	0	1	2	3	4
26. My vision changes before a headache begins.	0	1	2	3	4
27. I am unsteady on my feet all the time.	0	1	2	3	4
28. I am anxious much of the time.	0	1	2	3	4
29. When I cough I get dizzy.	0	1	2	3	4
30. When I get a headaches I am very sensitive to light (I try to find a dark room to rest).	0	1	2	3	4
31. I feel dizzy all of the time.	0	1	2	3	4