Vestibular Medical History Form

Welcome to Sawtooth Physical Therapy. Please take a moment to fill out your medical history as accurately and completely as possible. This information helps us to deliver the most comprehensive care to you. Your physical therapist will review this information with you during your first appointment.

Name: _____ Date of Birth: _____

CURRENT INJURY CONDITION:

Why are you coming here today (describe injury or condition)? _____

_____

When did your condition Begin? _____ Work Related: ☐ Yes ☐ No Next MD appointment *(date):* _____

Surgery Date *(if applicable)*: _____ Type of Surgery: _____

CURRENT SYMPTOMS:

Description of Symptoms: ☐ Vertigo (sense of spinning) ☐ off-balance ☐ Light headedness

Rate symptom severity in the past 5 days (*0 is "no problem," 10 is "couldn't be worse," how severe is the problem?*):

Symptoms at worst: _____ Symptoms at Best: _____

Description of spells: ☐ Constant ☐ Spontaneous ☐ Induced by motion ☐ Induced by position changes

Length of spells: ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Other _____

Have you received other therapies in the past 12 months? ☐ Yes ☐ No

Please check all that describes your symptoms:

☐ Spinning
☐ Lightheaded / swimming
☐ Off Balance / unsteady
☐ Blurry Vision
☐ Sense of tilting
☐ Stiffness / pain in neck
☐ Trouble walking
☐ Nausea / vomiting

Have you experienced any of the following symptoms / sensations with your problem?

☐ Difficulty Swallowing
☐ Blacking out / fainting
☐ Headaches
☐ confusion
☐ Numbness in arms or legs
☐ Ringing of ears / tinnitus
☐ Difficulty speaking
☐ Tingling around face or mouth
☐ Double or blurry vision

Hearing impairments? ☐ Yes ☐ No ☐ Other _____

Do you have a history of Migraine Headaches? ☐ Yes ☐ No ☐ Comments _____

MEDICAL CONDITIONS: (Do you have a history of?)

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Abnormal Bleeding	☐	☐	Degenerative Joint	☐	☐	Joint Pain
☐	☐	Angina	☐	☐	Depression	☐	☐	Lymphedema
☐	☐	Anxiety	☐	☐	Diabetes (Type 1)	☐	☐	Migraine Headaches
☐	☐	Arrhythmia	☐	☐	Diabetes (Type 2)	☐	☐	MRSA
☐	☐	Asthma	☐	☐	DVT	☐	☐	Multiple Sclerosis
☐	☐	Bipolar Disorder	☐	☐	Fibromyalgia	☐	☐	MI/Heart Attack
☐	☐	Blood Clotting Disorder	☐	☐	Frequent UTI	☐	☐	Osteoarthritis
☐	☐	Bowel Incontinence	☐	☐	GERD	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Psoriatic Arthritis
☐	☐	Carpal Tunnel Syndrome	☐	☐	Gout	☐	☐	PVD
☐	☐	Cellulitis	☐	☐	Heart Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Chronic Back Pain	☐	☐	Hep B	☐	☐	Scoliosis
☐	☐	Chronic Neck Pain	☐	☐	Hep C	☐	☐	Seizure Disorder
☐	☐	Crohn's Disease	☐	☐	Hiatal Hernia	☐	☐	Shortness of Breath
☐	☐	Closed Head Injury	☐	☐	High Cholesterol	☐	☐	Sleeping Disorder
☐	☐	Colitis	☐	☐	HIV/AIDS	☐	☐	TB
☐	☐	Congestive Heart Failure	☐	☐	Hypertension	☐	☐	Urinary Incontinence
☐	☐	COPD	☐	☐	Hypothyroidism	☐	☐	Other: _____
☐	☐	CVA (Stroke)	☐	☐	Irritable Bowel Syndrome	☐	☐	Other: _____

Do you have a pacemaker? ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No

MEDICATIONS:

Please list all prescription and over-the-counter: *(attach separate sheet if necessary):* _____

_____

_____

VITAMINS & SUPPLEMENTS:

Please list all vitamins & supplements: _____

_____

ALLERGIES:

Please list any known allergies: _____

SURGICAL HISTORY:

Please list all past surgeries with dates: _____

_____

DIAGNOSTIC TESTS:

Have you had any X-rays? MRI? CT Scan? Ultrasound? Other? related to this condition *(Please List):*

_____

_____

SOCIAL HISTORY:

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Packs/Day: _____

Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke for? _____ Packs/Day: _____

How many years ago did you quit smoking? _____

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Drinks/week: _____

Hobbies / Activities? _____

FUNCTIONAL STATUS:

Occupation: _____ Work Status: _____ Restrictions: _____

Normal Work Duties:	Yes	No (*able to perform)*		Yes	No
Sitting for extended periods of time	☐	☐	Lifting Heavy Weights	☐	☐
Standing for extended periods of time	☐	☐	Operating Heavy Equipment	☐	☐
Repetitive Bending	☐	☐	Driving	☐	☐
Repetitive Lifting	☐	☐	Typing / Computer Operation	☐	☐
Lifting moderate Weights	☐	☐	Walking	☐	☐

Have you fallen in the last 12 months? ☐ Yes ☐ No How Many falls? _____

If patient is a minor: Mother's Name: _____ Phone: _____
Father's Name: _____ Phone: _____

Patient (Guardian) Signature: _____ Date: _____

Dizziness Handicap Inventory

SAWTOOTH Physical Therapy

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "**Always**", or "**Sometimes**" or "**No**" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
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 out to dinner, going to movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away increase your problem?	☐	☐	☐
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 increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that 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 increase your problem?	☐	☐	☐
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 relationship 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 increase your problem?	☐	☐	☐