Balance & Neuro Physical Therapy

MEDICAL HISTORY/DIZZINESS QUESTIONNAIRE

Name: _____ Date: _____ AGE_____

Are you currently receiving other Physical Therapy Yes/No

Have you received Home Health services in the past year? Yes/No

If chief complaint is dizziness, please fill out section A and B; if not please proceed to section B.

Section A

Was the onset of your problem Sudden □ Gradual □ Traumatic □

When did your symptoms begin? _____

Are your symptoms constant? (ALWAYS THERE, 24 hours a day) **Yes/No**

How long do your symptoms last? Seconds □ Minutes □ Hours □ Days □

Do your symptoms ever occur when you are COMPLETELY STILL? **Yes/No**

Any symptoms made worse by: Lying down/rolling in bed □ head movements □ walking in the dark □ loud sounds □ supermarkets □ other □ **(Explain)**:_____

Have you experienced any of the following: falls □ sensation of being pushed down □ spinning □

Sensation of rocking or swaying □ does your vision "jump"□ ringing in the ear □

Fullness or pressure in the ear □ any hearing changes □ gait & balance instability □

Section B

Chief Complaint: _____

Have you fallen in the past year? **Yes/No**

Do you currently exercise? **Yes/No**

Do you feel unsteady? **Yes/No, If yes, with which activity**? _____

Please explain how your problem affects your daily life: _____

Are you currently under restrictions from your physician? **Yes/No** Explain: _____

Do you use a device for walking assistance? **Yes/No** **Cane** (at home) __ (in community) __ **Walker** (at home) __ (in community) __ **Other**_____

MEDICAL HISTORY: (Please circle all that apply)

Anxiety	Cataracts	Headaches	Kidney/Bladder Control	Pacemaker
Asthma	Dizziness	Hearing Impaired	Meniere's Disease	Parkinson's
Alzheimer's	Diabetes	Heart disease	Migraines	Peripheral Neuropathy
Arthritis	Epilepsy	High Blood Pressure	Multiple Sclerosis	Stroke
Cancer	Glaucoma	HIV/AIDS	Osteoporosis	Tuberculosis

Did you have Polio as a child? ___yes ___no What areas were affected?_____

Joint Replacement R / L _____ Other:_____

Have you had any operations? If yes please list: _____

_____

Please list all medications & DOSAGEs that you are currently taking: _____

_____

Please circle all diagnostic tests for this condition: **None** **MRI** **CAT Scan** **ENG** **VENG** **Other**: _____

Do you have any **pain** at this time? **YES/NO** If yes, where? _____ Now ___/10 Worst___/10 Best__/10

To the best of my knowledge and belief, the information I have given is complete and true. I acknowledge that, while unlikely, treatment may cause side effects such as muscle soreness, bruising, tenderness, fatigue, falls, burns, nausea and dizziness. I hereby give my consent to receive therapy services at the Center for Balance and Neurological Physical Therapy.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date**_____