

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: 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.

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) _____

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09.0021



Olathe Medical Center

20333 West 151st Street
Olathe, Kansas 66061

**PHYSICAL THERAPY
VESTIBULAR REHABILITATION
INTAKE QUESTIONNAIRE**

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O.M.C. No. 1398

PLACE
PATIENT LABEL
HERE

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 →→→

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