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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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 Do you have any allergies? ❑ No ❑ Yes, please list:	**REACTION**

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

PREVIOUS PROCEDURES / SURGERIES Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

CURRENT MEDICATIONS, INCLUDING HERBALS Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**
❑ See attached list			

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