

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
*To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.*

**HISTORY OF PRESENT CONDITION**

1. Reason for Referral \_\_\_\_\_  
 \_\_\_\_\_
2. Which of the following best describes your symptoms? (check all that apply)
 

<input type="checkbox"/> (1) imbalance	<input type="checkbox"/> (12) pain in ears
<input type="checkbox"/> (2) trouble walking	<input type="checkbox"/> (13) ringing in ears
<input type="checkbox"/> (3) staggering	<input type="checkbox"/> (14) hearing loss
<input type="checkbox"/> (4) sense of leaning/tilt	<input type="checkbox"/> (15) headache
<input type="checkbox"/> (5) undulations (as if on a boat)	<input type="checkbox"/> (16) pain in neck
<input type="checkbox"/> (6) vertigo (spinning events)	<input type="checkbox"/> (17) lightheadedness
<input type="checkbox"/> (7) sense of floating	<input type="checkbox"/> (18) disorientation
<input type="checkbox"/> (8) nausea/queasiness	<input type="checkbox"/> (19) poor concentration, memory or attention
<input type="checkbox"/> (9) visual confusion	<input type="checkbox"/> (20) fatigue
<input type="checkbox"/> (10) blurry vision	<input type="checkbox"/> (21) weakness (location) _____
<input type="checkbox"/> (11) jumping vision	<input type="checkbox"/> (22) other _____
3. When did you first notice this episode of symptoms (Please indicate a specific date if possible)? \_\_\_\_\_
4. Was the onset of this episode gradual or sudden? (Check one)  (1) gradual  (2) sudden
5. Which of the following best describes the reason for your symptoms?
 

<input type="checkbox"/> (1) a MVA (auto accident)
<input type="checkbox"/> (2) a fall
<input type="checkbox"/> (3) trauma
<input type="checkbox"/> (4) during recreation/sports
<input type="checkbox"/> (5) an infection
<input type="checkbox"/> (6) after taking drugs/antibiotics
<input type="checkbox"/> (7) aging
<input type="checkbox"/> (8) unknown
<input type="checkbox"/> (9) other _____
6. Since onset are your symptoms getting
 

<input type="checkbox"/> (1) better	<input type="checkbox"/> (2) worse	<input type="checkbox"/> (3) not changing
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7. Are your symptoms:
 

<input type="checkbox"/> (1) constant	<input type="checkbox"/> (2) provoked by head movement or activity	<input type="checkbox"/> (3) spontaneous
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8. Have you ever fallen?
 

<input type="checkbox"/> (1) no
<input type="checkbox"/> (2) yes-once in the last week
<input type="checkbox"/> (3) yes-more than once this week
<input type="checkbox"/> (4) other _____
9. What aggravates your symptoms?
 

<input type="checkbox"/> (1) lying down	<input type="checkbox"/> (5) visual motion
<input type="checkbox"/> (2) going to/rising from sitting	<input type="checkbox"/> (6) medication
<input type="checkbox"/> (3) riding in or driving a car	<input type="checkbox"/> (7) other _____
<input type="checkbox"/> (4) walking	
10. Have you ever had vestibular testing?
 

<input type="checkbox"/> (1) No	<input type="checkbox"/> (2) Yes	Results: _____
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11. Activities you do not do because of your problem: \_\_\_\_\_  
 \_\_\_\_\_
12. Since the onset of your current symptoms have you had:
 

<input type="checkbox"/> (1) any difficulty with control of bowel or bladder function
<input type="checkbox"/> (2) fever/Chills
<input type="checkbox"/> (3) any numbness in the genital or anal area
<input type="checkbox"/> (4) numbness
<input type="checkbox"/> (5) any dizziness or fainting attacks
<input type="checkbox"/> (6) weakness
<input type="checkbox"/> (7) unexplained weight change
<input type="checkbox"/> (8) night pain/sweats
<input type="checkbox"/> (9) malaise (vague feeling of bodily discomfort)
<input type="checkbox"/> (10) problems with vision/hearing
<input type="checkbox"/> (11) none of the above

**MEDICATION**

Please list any **prescription** medications you are currently taking (*pain pills, injections and/or skin patches etc.*):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Are you currently taking any of the following over the counter medications?
- |  |   |
|--|---|
| <input type="checkbox"/> (1) aspirin         | <input type="checkbox"/> (5) vitamins/mineral supplements |
| <input type="checkbox"/> (2) Tylenol         | <input type="checkbox"/> (6) Advil/Motrin/ibuprofen       |
| <input type="checkbox"/> (3) corticosteroids | <input type="checkbox"/> (7) other _____                  |
| <input type="checkbox"/> (4) antihistamines  |   |

**PREVIOUS FUNCTIONAL LEVEL**

- Independent in all activities** (work, community, home, recreation)

**Self Care**

- Independent in all self-care (bathing, toileting, dressing, etc.) activities
- Have difficulty performing self-care activities
- Need assistance with self-care activities
- Have difficulty performing household chores

**Social**

- Need assistance with activities in community outside of home

**Hobbies:** \_\_\_\_\_

**WORK HISTORY**

**Occupation** \_\_\_\_\_

- (1) employed full time       (5) student
- (2) employed part time       (6) retired
- (3) self employed       (7) unemployed
- (4) homemaker       (8) other \_\_\_\_\_

**Physical activities at work**

- (1) sitting       (6) computer use
- (2) standing       (7) heavy equipment operation
- (3) phone use       (8) driving
- (4) repetitive lifting       (9) other \_\_\_\_\_
- (5) heavy lifting

Are you currently receiving for seeking disability for this condition?       Yes       No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?  
 Yes       No

**LIVING SITUATION**

- (1) live alone
- (2) live with family member/others
- (3) live with caregiver
- (4) home/apartment
- (5) retirement complex (SNF/ ICF)
- (6) assisted living complex
- (7) other \_\_\_\_\_

**Setting**

- (1) stairs railing       (4) ramp
- (2) stairs no railing       (5) elevator
- (3) no stairs       (6) uneven ground
- other \_\_\_\_\_

**GENERAL HEALTH**

How would you rate your general health?

- Excellent       Average       Poor
- Good       Fair

Do you exercise outside of normal daily activities?

- (1) 5+days/wk       (4) occasionally
- (2) 3-4 days/wk       (5) zero
- (3) 1-2days/wk

Exercise, Sports/Recreation consisting of \_\_\_\_\_

Do you drink caffeine containing beverages?

- No       Yes      How many/much per day? \_\_\_\_\_

Do you smoke?

- No       Yes      Packs of cigarettes a day? \_\_\_\_\_

What is your stress level?

- Low       Medium       High

Are you seeing any health care providers other than the physical therapist for this current condition?(list)

\_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever had/ been diagnosed with any of the following conditions?

- Cancer (type)\_\_\_\_\_       Heart Problems
- Depression       High blood pressure
- Stroke       Lung Problems
- Kidney Problems       Blood Disorders
- Thyroid problems       Epilepsy/Seizures
- Diabetes       Allergies
- Multiple Sclerosis       Rheumatoid arthritis
- Arthritis       Osteoporosis
- Head Injury       Broken bone
- Stomach problems       Other \_\_\_\_\_
- Parkinson's Disease
- Circulation/vascular problems
- Infectious Diseases (i.e. hepatitis, tuberculosis)

Please list any recent/relevant past surgeries related to your current problem:

**SURGERY**      **DATE**

\_\_\_\_\_

**FAMILY HISTORY**

Has anyone in your immediate family (*parents, brothers, sisters*) ever been treated for any of the following?

- Diabetes       Cancer
- Heart disease       Arthritis
- High blood pressure       Osteoporosis
- Stroke       Psychological Condition
- Other \_\_\_\_\_