

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Describe the problem that brings you to therapy: \_\_\_\_\_

Date problem began: \_\_\_\_\_

Were you involved in an accident? If so, describe: \_\_\_\_\_

Before this problem began, how well were you functioning? \_\_\_\_\_

Since then, has your problem:  Worsened  Improved  Stayed same

What do you hope to achieve as a result of this treatment? \_\_\_\_\_

Do you have pain?  Yes  No → If yes, please rate your pain on the following pain scale. (circle the number)

0 1 2 3 4 5 6 7 8 9 10  
(none) (Severe)

Describe sensation: spinning, blurry vision, imbalance, undulation, nausea (upset stomach), other: \_\_\_\_\_

↓ Check those that apply to you	How often?	How Long?	Intensity? (0=normal, 10=most severe)
Constant Dizziness			
Occurs Spontaneously			
Is Provoked by Movement			
Is Provoked by Environment			
Is Provoked by:			

What has been your worst event? \_\_\_\_\_

Describe your symptoms at this moment. \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse (e.g., elevators, shopping, walking, driving, unstable surfaces, bending, walking in the dark, reacting, turning, etc.)? \_\_\_\_\_

**Other Factors:**

ENG Results? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Posturography Results? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Previous Treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Medications Tried? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Medications Currently Being Used: \_\_\_\_\_

**Functional Impact**

**Employment** Before: \_\_\_\_\_

Now: \_\_\_\_\_

**Activity Level** Before: \_\_\_\_\_

Now: \_\_\_\_\_

Executive Function (e.g., memory, organization, speech, etc.): \_\_\_\_\_

09.0021  
  
**Olathe Medical Center**  
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Olathe, Kansas 66061



**PHYSICAL THERAPY  
VESTIBULAR REHABILITATION  
INTAKE QUESTIONNAIRE**

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PLACE  
PATIENT LABEL  
HERE

Please put a check (✓) next to the response to each question that applies to you and your dizziness.

P1.	Does looking up make your problem worse?	___ Yes	___ Sometimes	___ No
E2.	Because of your problem, do you feel frustrated?	___ Yes	___ Sometimes	___ No
F3.	Because of your problem, do you restrict your travel for business or recreation?	___ Yes	___ Sometimes	___ No
P4.	Does walking down the aisle of a supermarket make your problem worse?	___ Yes	___ Sometimes	___ No
F5.	Because of your problem, do you have difficulty getting into or out of bed?	___ Yes	___ Sometimes	___ No
F6.	Does your problem significantly restrict your participation in social activities such as going to movies, dinner, dancing, parties, etc.?	___ Yes	___ Sometimes	___ No
F7.	Because of your problem, do you have difficulty reading?	___ Yes	___ Sometimes	___ No
P8.	Does doing more ambitious activities like sports, dancing, household chores such as sweeping, putting dishes away, etc., make your problem worse?	___ Yes	___ Sometimes	___ No
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	___ Yes	___ Sometimes	___ No
E10.	Because of your problem, have you been embarrassed in front of others?	___ Yes	___ Sometimes	___ No
P11.	Do quick movements of your head increase your problem?	___ Yes	___ Sometimes	___ No
F12.	Because of your problem, do you avoid heights?	___ Yes	___ Sometimes	___ No
P13.	Does turning over in bed make your problem worse?	___ Yes	___ Sometimes	___ No
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	___ Yes	___ Sometimes	___ No
E15.	Because of your problem, are you afraid people may think you are intoxicated?	___ Yes	___ Sometimes	___ No
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	___ Yes	___ Sometimes	___ No
P17.	Does walking down a sidewalk make your problem worse?	___ Yes	___ Sometimes	___ No
E18.	Because of your problem, is it difficult for you to concentrate?	___ Yes	___ Sometimes	___ No
F19.	Because of your problem, is it difficult for you to walk around your house in the dark?	___ Yes	___ Sometimes	___ No
E20.	Because of your problem, are you afraid to stay home alone?	___ Yes	___ Sometimes	___ No
E21.	Because of your problem, do you feel handicapped?	___ Yes	___ Sometimes	___ No
E22.	Has your problem placed stress on your relationships with members of your family or friends?	___ Yes	___ Sometimes	___ No
E23.	Because of your problem, are you depressed?	___ Yes	___ Sometimes	___ No
F24.	Does your problem interfere with your job or household responsibilities?	___ Yes	___ Sometimes	___ No
P25.	Does bending over make your problem worse?	___ Yes	___ Sometimes	___ No

"Dizziness Handicap Index" Jacobson, Newman; Arch Otolaryngol Head Neck Surg; 116:424, 1990

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Are you currently receiving any home health services?     YES     NO

Are you pregnant now or is there a chance you could be?     YES     NO

Have you taken steroids for a prolonged period of time?     YES     NO

Have you had any tests recently? (X-Ray, CT Scan, MRI, EMG, ECG, etc) \_\_\_\_\_

In the space below, please tell us anything else you think your therapist will need to know: \_\_\_\_\_

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