★★★ **Are you currently receiving ANY home health services? ❑ YES ❑ NO**

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 (none)	1	2	3	4	5	6	7	8	9	10 (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.):** ______________

➔➔➔ OVER ➔➔➔

09.0021

Olathe Medical Center
20333 West 151st Street
Olathe, Kansas 66061

PHYSICAL THERAPY
VESTIBULAR REHABILITATION
INTAKE QUESTIONNAIRE

9.25.2017; Rehab

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.

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

➔➔➔ OVER ➔➔➔

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year? ❑ YES ❑ NO If yes, please describe: ______________________________

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) ______________________________

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: ______________________
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: ___________
Preferred method of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Video ❑ Other: ________________

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

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? ☐ No ☐ Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS ☐ See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

TIME: ____________ DATE: __________ PATIENT SIGNATURE: ______________________________

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