INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
VESTIBULAR / BALANCE (Page 1)

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

SUBJECTIVE

THERAPIST COMMENTS:

Age: _____ When did your symptoms start? _____

Hand Dominance: ☐ Right ☐ Left Date of next Doctor's appointment: _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan
☐ VNG/ENG ☐ Other Results: _____

Have you ever had these symptoms before? ☐ Yes ☐ No Description: _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No If Yes, please describe:

☐ Medication: Beneficial? ☐ Yes ☐ No Explain: _____

☐ Injection: Beneficial? ☐ Yes ☐ No Explain: _____

☐ Physical Therapy: Beneficial? ☐ Yes ☐ No Explain: _____

Did you have surgery? ☐ Yes ☐ No Date of Surgery: _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ Yes ☐ No Explain: _____

FUNCTIONAL ABILITIES AND RESTRICTIONS

THERAPIST COMMENTS:

What activities are difficult to perform due to your condition? ☐ Squatting ☐ Sitting ☐ Standing

☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Driving ☐ Stairs ☐ Reaching ☐ Work Tasks

☐ Gripping/Pinching ☐ Kneeling ☐ Position Changes ☐ Holding/Carrying Objects

☐ Other: _____

_____

What activities make your <u>symptoms</u> WORSE?_____

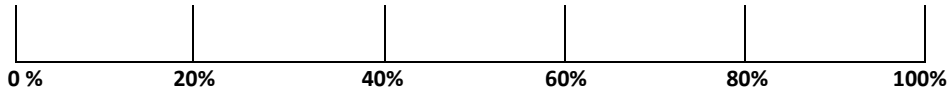
What activities make your <u>symptoms</u> BETTER? _____

What were you doing prior to this injury that you are unable to do currently? _____

_____

DIZZINESS RATING: In past six months, what percentage of the time has dizziness interfered with your activities?

Please mark on line below.



What household activities are you having trouble doing or cannot do by yourself? *(Please mark all that apply.)*

☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Grocery Shopping ☐ Yard Work

☐ Other: _____

_____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
VESTIBULAR / BALANCE (Page 2)

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

CURRENT COMPLAINTS

Symptom Description:

□ Lightheaded □ Dizzy □ Spinning □ Motion Sickness

How long do your symptoms last? □ < 1 min □ 5-10 min □ Continuous □ Hours □ Other: _____

When was the last time symptoms occurred? _____

Do your symptoms (check all that apply): □ Occur spontaneously □ Occur with movement

□ Occur with positional changes □ Other: _____

THERAPIST COMMENTS:

SAFETY PRECAUTIONS

Sense of Balance:

Have you had any falls in the past 12 months? □ Yes □ No If Yes, how many times? _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

When was the last fall(s)? _____

Was fall(s) because of dizziness? □ Yes □ No

Do you experience near falls or need to hold onto walls, furniture, etc. to maintain your balance at times?

□ Yes □ No If Yes, describe: _____

How often? _____

When was the last time this occurred? _____

Do you lose your balance while walking? □ Yes □ No

If Yes, check all that apply: □ Uneven surfaces □ Dark □ Outside □ With Fatigue

Do you feel like you drift to one side while walking? □ Yes □ No

If Yes, to which side? □ Right □ Left □ Both

THERAPIST COMMENTS:

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ Presently Working: □ Yes □ No

If Yes, □ Full Duty □ Limited Duty: Restrictions: _____ # Days Off Work: _____

Job Duties: □ Sitting □ Computer Work □ Bending □ Heavy Lifting □ Traveling □ Standing
□ Reaching □ Crawling □ Twisting □ Walking □ Pushing/Pulling □ Gripping/Pinching
□ Other: _____

Are you now, or have you ever been disabled (service or work)? □ Yes □ No If Yes, when? _____
If Yes, please explain: _____

What is your current living arrangement? □ Alone □ Spouse □ Partner □ Family □ Other: _____

Does your home have stairs? □ Yes □ No If Yes, # of stairs: _____

If Yes, do your stairs have handrail? □ Yes □ No If Yes, which side going up? □ Right □ Left □ Both

Do you currently use any Tobacco products? □ Yes □ No If yes, what type? _____ Frequency: _____

THERAPIST COMMENTS:

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (i.e., by mouth)*] that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals):

_____

_____

THERAPIST COMMENTS:
□ See Attached List

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ Date: _____