

# OakBend Balance & Neuro PT

## MEDICAL HISTORY/DIZZINESS QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

AGE \_\_\_\_\_

Are you currently receiving other Physical Therapy Yes/No

Have you received Home Health services in the past year? Yes/No

If chief complaint is dizziness, please fill out section A and B; if not please proceed to section B.

### Section A

Was the onset of your problem Sudden  Gradual  Traumatic

When did your symptoms begin? \_\_\_\_\_

Are your symptoms constant? (ALWAYS THERE, 24 hours a day) Yes/No

How long do your symptoms last? Seconds  Minutes  Hours  Days

Do your symptoms ever occur when you are COMPLETELY STILL? Yes/No

Any symptoms made worse by: Lying down/rolling in bed  head movements  walking in the dark  loud sounds  supermarkets   
other  (Explain): \_\_\_\_\_

Have you experienced any of the following: falls  sensation of being pushed down  spinning

Sensation of rocking or swaying  does your vision "jump"  ringing in the ear

Fullness or pressure in the ear  any hearing changes  gait & balance instability

### Section B

Chief Complaint: \_\_\_\_\_

Have you fallen in the past year? Yes/No

Do you currently exercise? Yes/No

Do you feel unsteady? Yes/No, If yes, with which activity? \_\_\_\_\_

Please explain how your problem affects your daily life: \_\_\_\_\_

Are you currently under restrictions from your physician? Yes/No Explain: \_\_\_\_\_

Do you use a device for walking assistance? Yes/No Cane (at home) \_\_ (in community) \_\_ Walker (at home) \_\_ (in community) \_\_  
Other \_\_\_\_\_

MEDICAL HISTORY: (Please circle all that apply)

Anxiety	Cataracts	Headaches	Kidney/Bladder Control	Pacemaker
Asthma	Dizziness	Hearing Impaired	Meniere's Disease	Parkinson's
Alzheimer's	Diabetes	Heart disease	Migraines	Peripheral Neuropathy
Arthritis	Epilepsy	High Blood Pressure	Multiple Sclerosis	Stroke
Cancer	Glaucoma	HIV/AIDS	Osteoporosis	Tuberculosis

Did you have Polio as a child? \_\_\_yes \_\_\_no What areas were affected? \_\_\_\_\_

Joint Replacement R / L \_\_\_\_\_ Other: \_\_\_\_\_

Have you had any operations? If yes please list: \_\_\_\_\_

Please list all medications & DOSAGES that you are currently taking: \_\_\_\_\_

Please circle all diagnostic tests for this condition: None MRI CAT Scan ENG VENG Other: \_\_\_\_\_

Do you have any pain at this time? YES/NO If yes, where? \_\_\_\_\_ Now \_\_\_/10 Worst \_\_\_/10 Best \_\_\_/10

To the best of my knowledge and belief, the information I have given is complete and true. I acknowledge that, while unlikely, treatment may cause side effects such as muscle soreness, bruising, tenderness, fatigue, falls, burns, nausea and dizziness. I hereby give my consent to receive therapy services at the Center for Balance and Neurological Physical Therapy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_