Balance & Neuro Physical Therapy

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ AGE_____

Are you currently receiving Physical or Occupational Therapy □**Yes** □**No**

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

Chief Complaint: _____

What is your goal for therapy? _____

If chief complaint is DIZZINESS or VERTIGO, 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 □ vision "jumps" □change in vision □ringing in the ear □ fullness or pressure in the ear □hearing changes □gait & balance instability

Section B

Please explain how your problem affects your daily life: _____

What is your occupation?_____ Do your symptoms currently affect your work? □**Yes** □**No**

Do you currently exercise? □**Yes** □**No**

Have you fallen in the past year? □**Yes** □**No**

Do you feel unsteady? □**Yes** □**No, If yes, with which activity**? _____

Do you have any **pain** at this time? □**Yes** □**No** If yes, where?_____Now____/10 Worst____/10 Best____/10

Do you use a device for walking assistance? □**Cane** □**Walker** □**Rollator**
Please list any other medical equipment you have at home: _____

Are you currently under restrictions from your physician? □**Yes** □**No** Explain: _____

MEDICAL HISTORY: (Please circle all that apply)

No Significant History	Diabetes Mellitus I/II	Anxiety/Depression	Parkinson's Disease	Lupus
Alzheimer's/Dementia	Peripheral Neuropathy	Cardiovascular Disease	Fibromyalgia	Epilepsy
Migraine/Headaches	Traumatic Brain Injury	Meniere's Disease	Osteoarthritis	CVA/Stroke
High Blood Pressure	History of Cancer	Multiple Sclerosis	Cataracts/Glaucoma	Concussion

Other:_____

Please list any pertinent **operations** you may have had (i.e**. joint replacements**, **pacemaker**, etc.):_____

_____

Please list all **medications** & DOSAGEs that you are currently taking: _____

_____

Please circle all diagnostic tests *for this condition*: **None** **MRI** **CAT Scan** **ENG** **VNG** **Other**: _____

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**_____