Shull Physical Therapy Center
4646 Corona Dr. Ste. #130
Corpus Christi, TX 78411
(361) 225-2539 FAX (361) 225-0851

Vestibular Rehabilitation
Dizziness & Balance Medical History Questionnaire

Please answer the following questionnaire to assist the physical therapist treating your case. If there are any questions, please ask the receptionist. Thank you for your cooperation during this investigative process.

Today's Date:_____

Name:_____ Date of Birth:_____

I. Initial Onset

Describe what happened the first time you experienced dizzy/imbalanced symptoms.

II. Symptoms

In the box after each symptom, rate the severity of that symptom using a scale of **0-10**, with 10 being most severe.

Symptom	1-10	Symptom	1-10	Symptom	1-10	Symptom	1-10
Dizziness		Spinning		Lightheadedness		Rocking/Tilting	
Visual Changes		Headache		Fatigue		Unsteadiness	
Falling		Noise in ears		Brain fog		Fainting	
Hearing Loss		Double Vision		Fullness, pressure, or pain in ear		Other:	

III. History of Present Illness

- Problem start date:_____
- Was the problem associated with a related event (i.e. head injury)? ◯ **Yes** ◯ **No**
  If yes, please explain:_____
- Was the onset of your symptoms: ◯ **sudden** ◯ **gradual** ◯ **overnight** ◯ **other**
  Describe:_____
- Are your symptoms: ◯ **constant** ◯ **variable** (i.e. come and go in spells)
  If variable:
  The spells occur every # of: _____hours _____ days _____weeks _____months _____ years

  Do you have any warning signs when a spell is about to happen?
  _____
  Are you completely free of symptoms between spells? ◯ **Yes** ◯ **No**
- Do your symptoms occur when changing positions? ◯ **Yes** ◯ **No**

  If yes, check all that apply:

	Rolling your body to the left		Rolling your body to the right
	Moving from a lying to sitting position		Looking up with your head back
	Turning head side to side while sitting/standing		Bending over with your head down

- When symptoms occur, do you need to support yourself to stand or walk?
  ◯ **Yes** ◯ **No** How do you support yourself?_____
- When walking, do you: ◯ **veer left?** ◯ **veer right?** ◯ **remain straight?**
- Have you ever fallen as a result of your current problem? ◯ **Yes** ◯ **No**
- Do you have a history of any of the following?
  If yes, check all that apply:

	Migraines		Seizures		Macular Degeneration		Stroke
	Multiple Sclerosis		Neuropathy		Panic attacks/Anxiety		Concussion
	Cervical spine arthritis		Glaucoma		Congestive heart failure		Ataxia
	Parkinson's disease		Tumors		Diabetes Miletus		Depression

- Do you have difficulty hearing? ◯ **Right Ear** ◯ **Left Ear** ◯ **No**
  When did this start? _____
- Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ◯ **Yes** ◯ **No**

IV. Prior relevant medical evaluations, diagnostic testing, and treatment:

- Have you seen other healthcare providers for your condition? ◯ **Yes** ◯ **No**
  If yes, who? ◯ **Primary care doctor** ◯ **ENT/HNS doctor** ◯ **Neurologist**
  ◯ **Cardiologist** ◯ **Emergency Room doctor** ◯ **Physical therapist**
- Have you had any of the following done for this condition elsewhere?

Test/Therapy	**When**	**Where**	**Results**
ENG/VNG			
CT Scan or MRI			
Rehabilitation (PT or OT)			Did it help? ◯ Yes ◯ No

- Are you currently taking any medications?
  ◯ Meclizine
  ◯ Ativan
  ◯ Hydrochlorothiazide
  Other medications:
  _____

Prior Surgical History

Surgery	**Year**

V. Additional Information

Is there any additional information you would like the therapist to know?

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ **Date:** _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

Therapist Use Only

Comorbidities:

☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____