



*Please indicate on the diagram above, where the present symptoms are located.

Patient Name: _____ DOB: _____

Referring Physician: _____ Family Physician: _____

Date of injury or Onset of symptoms? _____ Cause of Symptoms? _____

Frequency of your symptoms? Constant Intermittent Getting better Worsening Staying the same

On a Scale of 1-10 (10 being the highest), please rate your current level of dizziness? Now _____ Best _____ Worst _____

What Activities *increase* your symptoms? _____

What *decreases* your symptoms? _____

Has this condition caused any falls? Y or N If yes how many falls in the last 12 months? _____

Do you have a history of motion sickness? Y or N

Do you have any headaches with this condition? Y or N Right or Left

Neck Pain? Y or N Ear Ringing? Y or N Sinus Problems? Y or N

Previous treatment for this condition? PT OT Massage Chiropractic Injection Surgery Exercise Meds Acupuncture

Medications: pain, anti-inflammatory, muscle relaxers, nausea, allergy, nerve, anxiety, blood pressure, heart, stomach, over the counter, motion sickness, vitamins, herbals, topical creams

Special Tests: (Please circle) X-Ray MRI CT Scan ENG Hearing Test Blood Work EMG Biopsy

Results _____

Please List any Surgeries to the head, neck or upper body and estimated Dates?

Past Medical History: Diabetes- Heart Disease- Stroke- COPD- Vascular Disease- Infection- Fibromyalgia- Parkinson's- MS- Whiplash- Concussion- Stomach Problems- Arthritis- Osteoporosis- Cancer- Vertigo- Motion Sickness- Auto immune disease- Neuropathy- Muscle Atrophy- Acid Reflux- Headaches/Migraines

Patient Signature _____

Date _____

Vestibular PT Intake Form