



Patient's Name _____

Today's Date ____/____/____

Balance/Dizziness Intake Form

Occupation: _____ Full-time Part-time Other

Primary Concern:

History of falls? No Yes If yes how often? _____ When was last fall? _____

Describe the problem that brings you to therapy: _____

Date problem began: _____ Since then, has your problem: Worsened Improved Same

Have you experienced a recent trauma? No Yes If yes describe _____

Have you ever experienced this problem before? No Yes If yes, please describe: _____

Symptoms:

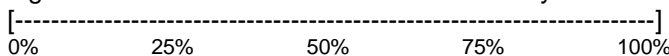
Symptom Description (circle all that apply):

Light Headedness	Visual Disturbances	Disorientation	Hearing Loss
Headaches	Rocking/ Swaying	Difficulty with Memory	Ringing in Ears
Nausea	Spinning	Facial Numbness	Ear Fullness/ Pressure
Passing out/ Fainting	Balance Difficulty	Fatigue/ Weakness	Other: _____

How often do symptoms occur? Daily Weekly Constantly

How long do symptoms last? Seconds Minutes Hours Days

In the last WEEK what percentage of the time has dizziness interfered with your activities? Mark on line below.



Symptoms increase with (circle all that apply):

Rolling in Bed	Turn Head	Walking	Bearing down/ Straining	Reading
Lying to Sit	Look up/Down	Crowds	Lying Down	Loud Noises
Sit to Stand	Bending/ Squatting	Driving	Cough/ Sneeze	Other

Medical History:

List of current medications including prescriptions, vitamins, herbals, and over the counter medications.

Current Medications	Dosage	Frequency	Route
Example: Asprin	200mg	3 times/day	by mouth

Allergies:

Surgical History:

Have you had any of the following medical or rehabilitative services for this injury/episode?

Type of Service	No	Yes	Treatment/Surgery	When	Provider Name
Chiropractic					
GP Office Visit					
Orthopedic					
Physical Therapy					
MRI/ X-Rays/ CT Scan					
Neurology					
Emergency Room Care					



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Please mark all of the following that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/>Pacemaker/Nitroglycerin | <input type="checkbox"/> Neurological Disorder _____ |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/>Multiple Sclerosis |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Depression | <input type="checkbox"/>Parkinson's Disease |
| <input type="checkbox"/> Blood/Circulation Problems _____ | <input type="checkbox"/> Diabetes (Type 1 or 2) _____ | <input type="checkbox"/>Peripheral Neuropathy |
| <input type="checkbox"/>Clots | <input type="checkbox"/> Ear Problems _____ | <input type="checkbox"/>Seizures |
| <input type="checkbox"/>Coronary/Peripheral Artery Disease | <input type="checkbox"/>Hearing Loss | <input type="checkbox"/> Orthopedic Problems _____ |
| <input type="checkbox"/>High Blood Pressure | <input type="checkbox"/>Vertigo/Dizziness | <input type="checkbox"/>Arthritis |
| <input type="checkbox"/>Hyper/Hypoglycemia | <input type="checkbox"/> Female Problems _____ | <input type="checkbox"/>Fracture/Broken Bone |
| <input type="checkbox"/>Poor Circulation | <input type="checkbox"/>Endometriosis | <input type="checkbox"/>Joint Pain/Problems |
| <input type="checkbox"/> Bladder/Bowel Problems _____ | <input type="checkbox"/>Fibroids | <input type="checkbox"/>Osteoporosis/Osteopenia |
| <input type="checkbox"/>Diverticulitis | <input type="checkbox"/>Menopause | <input type="checkbox"/> Polio |
| <input type="checkbox"/>Incontinence | <input type="checkbox"/>Pregnant (or possible pregnancy) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing Problems _____ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/>Asthma | <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Injuries _____ |
| <input type="checkbox"/>COPD | <input type="checkbox"/> Infections _____ | <input type="checkbox"/>Head Injury |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/>Hepatitis | <input type="checkbox"/>Motor Vehicle Accident |
| <input type="checkbox"/> Cardiac Problems _____ | <input type="checkbox"/>MRSA | <input type="checkbox"/>Traumatic |
| <input type="checkbox"/>Angina/Chest | <input type="checkbox"/> Major Spinal Injury | <input type="checkbox"/>Other _____ |
| <input type="checkbox"/>Congestive Heart Disease | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/>Heart Disease | <input type="checkbox"/> Mood Disorder _____ | |

Height: ____' ____" **Weight:** _____ lbs.

Are you currently in pain? Yes _____ **No** _____ **Where:** _____

If yes, pain level: 0 1 2 3 4 5 6 7 8 9 10 (circle one)
(0=no pain, 10= pain)

Patient/Guardian Signature

Date