ELEMENT PHYSICAL THERAPY
We are the balance experts

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.

[----------]

0% 25% 50% 75% 100%

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:

❑Anxiety
Blackouts
❑Blindness
❑Blood/Circulation Problems_____
❑….Clots
❑….Coronary/Peripheral Artery Disease
❑….High Blood Pressure
❑….Hyper/Hypoglycemia
❑….Poor Circulation
❑Bladder/Bowel Problems_____
❑….Diverticulitis
❑….Incontinence
❑Breathing Problems_____
❑….Asthma
❑….COPD
❑Cancer_____
❑Cardiac Problems_____
❑….Angina/Chest
❑….Congestive Heart Disease
❑….Heart Disease
❑….Pacemaker/Nitroglycerin
❑Carpal Tunnel
❑Depression
❑Diabetes (Type 1 or 2)_____
❑Ear Problems_____
❑….Hearing Loss
❑….Vertigo/Dizziness
❑Female Problems_____
❑….Endometriosis
❑….Fibroids
❑….Menopause
❑….Pregnant (or possible pregnancy)
❑Fibromyalgia
❑Frequent Falls
❑Infections_____
❑….Hepatitis
❑….MRSA
❑Major Spinal Injury
❑Migraine Headaches
❑Mood Disorder_____
❑Neurological Disorder_____
❑….Multiple Sclerosis
❑….Parkinson's Disease
❑….Peripheral Neuropathy
❑….Seizures
❑Orthopedic Problems_____
❑….Arthritis
❑….Fracture/Broken Bone
❑….Joint Pain/Problems
❑….Osteoporosis/Osteopenia
❑Polio
❑Stroke
❑Tuberculosis
❑Injuries_____
❑….Head Injury
❑….Motor Vehicle Accident
❑….Traumatic
❑….Other_____
❑Other_____

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**

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