

Foothills Physical Therapy
Vestibular Health History Intake
603-225-5132 – www.foothillsphysicaltherapy.com

Date: _____ Name: _____ Age: _____

Referring Physician: _____

Occupation: _____ Hours per week: _____

Are your symptoms better, worse or staying the same: _____

Please describe the Major problem or reason you are seeing us: _____

How long do your symptoms last? Seconds: _____ Minutes: _____ Hours: _____ Days: _____

When did your symptoms first begin? _____

Can you provoke or bring on your symptoms? _____ If yes, how? _____

Does it happen in bed? _____ lying down? _____ getting up? _____ rolling over? _____

Does it happen in grocery/department stores? _____

Please rate on a scale of 1 (little problem) to 10 (couldn't be worse), how severe is this problem?

TODAY: _____/10 -- at Worse: _____/10

Check all that describe your symptoms:

- | | |
|---|--|
| <input type="checkbox"/> Spinning | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Lightheaded/swimming | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Off balance/unsteady | <input type="checkbox"/> Worse with change in position |
| <input type="checkbox"/> Trouble walking | <input type="checkbox"/> Sense of tilting |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Stiff/pain full neck |
| <input type="checkbox"/> Worse reaching over head | <input type="checkbox"/> Worse with quick movements |

Have you experienced any of the following symptoms/sensations with your problem?

- | | |
|---|--|
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Difficulty speaking |
| <input type="checkbox"/> Blacking out/fainting | <input type="checkbox"/> Tingling around the face or mouth |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Double/blurred vision |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Change in hearing |
| <input type="checkbox"/> Ringing in ears/tinnitus | <input type="checkbox"/> Numbness in arms or legs |

Do you take medication for this problem? _____

Do you have a history of any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Whiplash/motor vehicle accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Jaw problems (TMJ/Clenching or grinding teeth) |
| <input type="checkbox"/> Ear surgery | <input type="checkbox"/> Hearing loss/use hearing aids |

Have you or any immediate family member ever been diagnosed with: (Please Circle Yes or No, Self and/or Family)

Cancer	yes	no	self	family	Angina/Chest Pain	yes	no	self	family
High Blood Pressure	yes	no	self	family	Stroke	yes	no	self	family
Diabetes	yes	no	self	family	Arthritis	yes	no	self	family
Heart Disease	yes	no	self	family					

Have you had or recently experienced:

Nausea/Vomiting	yes	no	Fever/Chills/Sweats	yes	no
Numbness/tingling	yes	no	Muscular Weakness	yes	no
Fainting Spells	yes	no	Dizziness	yes	no
Night Pain	yes	no	Headaches	yes	no
Surgery	yes	no	Hospitalization	yes	no
Unexplained weight loss	yes	no	Bowel/bladder changes	yes	no

If yes, please explain: _____

Do you have a history of:

Shortness of Breath	yes	no	Allergies	yes	no
Asthma	yes	no	Bronchitis	yes	no
Kidney Disease/stone	yes	no	Polio	yes	no
Emphysema	yes	no	Anemia	yes	no
Rheumatic Fever	yes	no	Ulcers	yes	no
Seizures	yes	no	Other illnesses	yes	no

Have you had any recent illnesses, including upper respiratory infections, flu, or urinary tract infections? yes no

Do you smoke? yes no If yes, how many packs per day? _____ For how many years? _____

Do you use alcohol? yes no If yes, how many drinks per day? _____ How many per week? _____

Do you consume caffeine? yes no Of yes, how many cups per day? _____

Do you have any allergies to latex? yes no

Do you currently use or have you ever used a C-PAP Machine? Yes No

Please list your medications: _____

How often do you feel stress is a significant factor in your life? (circle one)

Never Seldom Occasionally Regularly Always

In general, do you sleep well? yes no

Please list leisure activities and current exercise routines: _____

Date of last completed physical examination: Month _____ Year _____

Woman: Date of last menstrual period: _____ Might you be pregnant? yes no

What do you want Physical Therapy to do for you? _____