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:

___Spinning
___Lightheaded/swimming
___Off balance/unsteady
___Trouble walking
___Nausea/vomiting
___Worse reaching over head
___Blurry Vision
___Constant
___Worse with change in position
___Sense of tilting
___Stiff/pain full neck
___Worse with quick movements

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

___Difficulty swallowing
___Blacking out/fainting
___Headaches
___Confusion
___Ringing in ears/tinnitus
___Difficulty speaking
___Tingling around the face or mouth
___Double/blurry vision
___Change in hearing
___Numbness is arms or legs

Do you take medication for this problem? _____

Do you have a history of any of the following?

___Whiplash/motor vehicle accident
___Motion sickness
___Ear surgery
___Head injury
___Jaw problems (TMJ/Clenching or grinding teeth
___Hearing loss/use hearing aids

Name: _____

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? _____

_____