Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan
☐ VNG/ENG ☐ Other **Results:** _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?
☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities are difficult to perform due to your condition? ☐ Squatting ☐ Sitting ☐ Standing
☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Driving ☐ Stairs ☐ Reaching ☐ Work Tasks
☐ Gripping/Pinching ☐ Kneeling ☐ Position Changes ☐ Other: _____

_____

What activities make your <u>symptoms</u> WORSE? _____

What activities make your <u>symptoms</u> BETTER? _____

What were you doing prior to this injury that you are unable to do currently? _____

_____

DIZZINESS RATING: In past six months, what percentage of the time has dizziness interfered with your activities? Please mark on line below.

0 % 20% 40% 60% 80% 100%

What household activities are you having trouble doing or cannot do by yourself? ***(Please mark all that apply.)***

☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Grocery Shopping ☐ Yard Work
☐ Driving ☐ Other: _____

_____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

CURRENT COMPLAINTS

If you have pain, what is your pain level?

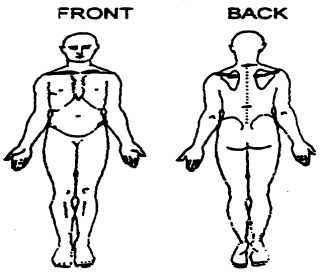
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Are your symptoms:

□ **Constant** □ **Come and Go** □ **Ache** □ **Deep** □ **Superficial** □ **Dull**
□ **Sharp** □ **Shooting** □ **Burning** □ **Numbness/Tingling**
□ **Other:** _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? □ **Yes** □ **No**
If Yes, □ **Morning** □ **Night** □ **Other:**_____
Does your pain progress as the day goes along? □ **Yes** □ **No**
If Yes, please explain: _____
Do you have difficulty falling asleep? □ **Yes** □ **No**
If Yes, please explain: _____
Do you wake due to pain? □ **Yes** □ **No** **If Yes, # of times per night:** _____

Symptom Description:

□ **Lightheaded** □ **Dizzy** □ **Spinning** □ **Motion Sickness**
How long do your symptoms last? □ < 1 min □ 5-10 min □ Continuous □ Hours □ Other: _____

When was the last time symptoms occurred? _____

Do your symptoms (check all that apply): □ **Occur spontaneously** □ **Occur with movement**
□ **Occur with positional changes** □ **Other:** _____

THERAPIST COMMENTS:

SAFETY PRECAUTIONS

Sense of Balance:

Have you had any falls in the past 12 months? □ **Yes** □ **No**

If Yes, how many times? _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

When was the last fall(s)? _____

Was fall(s) because of dizziness? □ **Yes** □ **No**

Do you experience near falls or need to hold onto walls, furniture, etc. to maintain your balance at times?

□ **Yes** □ **No** **If Yes, describe:** _____

How often? _____

When was the last time this occurred? _____

Do you lose your balance while walking? □ **Yes** □ **No**

If Yes, check all that apply: □ Uneven surfaces □ Dark □ Outside □ With Fatigue

Do you feel like you drift to one side while walking? □ **Yes** □ **No**

If Yes, to which side? □ Right □ Left □ Both

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ Yes ☐ No

If Yes, ☐ Full Duty ☐ Limited Duty: Restrictions: _____ # Days Off Work: _____

Job Duties: ☐ Sitting ☐ Computer Work ☐ Bending ☐ Heavy Lifting ☐ Traveling ☐ Standing
☐ Reaching ☐ Crawling ☐ Twisting ☐ Walking ☐ Pushing/Pulling
☐ Gripping/Pinching ☐ Other: _____

Are you now, or have you ever been disabled (service or work)? ☐ Yes ☐ No **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____

Does your home have stairs? ☐ Yes ☐ No **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ Yes ☐ No **If Yes, which side going up?** ☐ Right ☐ Left ☐ Both
Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS MEDICAL HISTORY

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Migraines	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**
☐ Cataracts	☐ Macular Degeneration	☐ Meniere's disease

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____
_____
_____
_____

THERAPIST COMMENTS:
☐ **See Attached List**
_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
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_____
_____
_____

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals):
_____
_____
_____

THERAPIST COMMENTS:
☐ **See Attached List**
_____
_____
_____

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____
_____
_____

THERAPIST COMMENTS:
_____
_____

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____
Therapist's Signature: _____ **License #:** _____ **Date:** _____
Printed Therapist's Name: _____