CENTRAL
Physical Therapy
PEOPLE YOU KNOW.
EXPERIENCE YOU CAN TRUST.

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NAME:_____ **AGE:**_____ **DATE:** _____

PRESENT OCCUPATION:_____

Name and **address** of physician(s) you wish our report to be sent:

_____

_____

_____

Please answer these questions to the best of your ability. PLEASE BRING QUESTIONNAIRE WITH YOU – DO NOT MAIL IT BACK. Please give necessary details for yes answers. We realize that this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you related questions during your visit. If you need to CHANGE or CANCEL an appointment, please contact our office.

Describe your major problem or the reason why you are seeing us.

Please describe in detail the circumstances and date in which the problem began and what were your initial symptoms and problems. Was there any stress or anxiety around the onset of the problem?

If you have spells, please describe a typical spell in as much detail as possible and describe the frequency and duration of the spells.

What do you personally think your problem is due to?

1. **Please check the symptoms which characterize your problem and grade their severity from 2 (marked), 1 (moderate) to 0 (none). Put 0 if you do not have these symptoms.**
   a. Sensation of imbalance
      ( ) Trouble with walking
      ( ) Poor balance
      ( ) Falls
   b. Sense of movement of the environment or of one's own body
      ( ) Rotation (spinning, tumbling or cartwheeling)
      ( ) Linear movement or pulling
      ( ) Tilt
   c. Sensations not associated with movement of the environment
      ( ) Lightheadedness or impending faint
      ( ) Floating
      ( ) Swimming
      ( ) Giddiness
      ( ) Rocking
      ( ) Spinning inside of head
      ( ) Fear or avoidance of being in public places

d. Associated symptoms
   ( ) Sweating
   ( ) Nausea
   ( ) Vomiting
   ( ) Queasiness
e. Impaired vision
   ( ) Double vision
   ( ) Blurred vision
   ( ) Flashes of light
   ( ) Jumping of vision when walking or riding in a car

2. To what extent is your dizziness or imbalance brought on by:

(Check one answer for each question.	**None**	**Some**	**Severely**
Turning over in bed, bending over or looking up			
Standing up			
Rapid head movements			
Walking in a dark room			
Walking on uneven surfaces			
Loud noises			
Cough, sneeze, strain, laugh, blowing up balloons			
Movement of objects in the environment			
Moving your eyes while your head is still			
Wide open spaces			
Tunnels, bridges, supermarkets			
Menstrual periods			

3. Other questions concerning dizziness	**YES**	**NO**
Can you bring on your dizziness voluntarily? If answered yes, please describe.		
Do or did you have moderate-severe motion (car or boat) sickness. If yes, when did it start?		
Do or did you avoid situations in which you were tumbled or spun (amusement rides, merry-go-rounds)? When did you begin?		
Has anyone observed jerking of your eyes with dizzy spells?		

4. Have you ever had: (If yes, please give details.)

	YES	NO
Infections of ears		
Difficulty with your hearing		
Pain, fullness, popping or pressure in ear		
Pain, pins/needles, numbness, twitching, or weakness of face		
Crossed eyes or lazy eye.		
Ringing in ears (called tinnitus) If you answered yes to tinnitus, please answer the following questions.		
State the frequency and duration of the tinnitus during the past 6 months		
Please circle the correct answers. The tinnitus is primarily		
in the left, right or both ears. It is steady, pulsating.		
It is high, low pitched.		

5. REVIEW OF SYSTEMS (If yes, give details.)

Within the last 6 months have you noted:	YES	NO
Significant loss in strength		
Significant loss of energy		
10 lb. or more weight change (if yes, up__or down		
Significant memory loss (amnesia)		
Significant change in hand writing		
Pins and needles, numbness in arms or legs		
Muscle or joint aches (If yes, which muscles or joints_____)		
Urinary incontinence (leakage of urine)		
Problems with sleeping		
Shortness of breath		
Trouble chewing_____ or swallowing_____ or speaking_____		
Incoordination		
Palpitations (irregular or fast beating) of the heart		
Headaches		
If you answered yes to headaches, please answer the following:		
Approximate age they began _____;		
Number per month _____; Pain intensity (1–10 with 10 the most severe) _____		
Since the onset of headaches have you had at least 5 headaches that:		
Lasted at least 4 hours		
Started on one side of the head, if yes usually which side?		
Were throbbing or pulsatile in quality?		
Were severe enough to interfere with your schedule?		
Were aggravated by routine physical activity?		
Were associated with nausea and/or vomiting?		
Were aggravated by bright lights or loud noises?		

6. PAST MEDICAL HISTORY (If yes, give details.)

Have you had any injuries due to trauma? (If yes, please describe the injury and when it occurred.)

Have you had any surgery? (If yes, please describe the surgery and when it occurred.)

Have you been exposed to any of the following? (If yes please, describe the exposure and when it occurred.)	**YES**	**NO**
Child abuse		
Intravenous antibiotics		
Loud noises (guns, machinery, loud music)		
Drug therapy for cancer (if yes, what type)		

Have you had any of the following infections? (If yes, give details.)	**YES**	**NO**
Syphilis or venereal disease		
Lyme disease		
Meningitis		
Other infections		

Has your past or present health been affected by: (If yes, give details.)	**YES**	**NO**
Heart problems		
Diabetes		
Thyroid disorders		
Treatment by a psychiatrist_____ or counselor_____		
Depression_____, anxiety_____, severe stress_____, phobias_____		
High cholesterol		
High_____ or low_____ blood pressure		
Pain in back of jaw (TMJ), grinding		
Loss of consciousness (faints)		
Seizures or convulsions		
Arthritis		
Neck pain		

List all major illnesses, injuries, and surgeries not described above

7. SOCIAL HISTORY

	YES	NO
Do or did you use alcohol? How much?		
Do or did you ever smoke:		
If so how many packs/day?		
What age did you start?		
If you quit at what age?		
How many cups of caffeinated drink per day (coffee, tea, soda)?		

8. FAMILY HISTORY

Which family members (dad, mother, children) have or had:

Headaches
Meniere's syndrome
Hearing loss
Vertigo or dizzines
Balance problems or tremor
Diabetes
Cancer or brain tumors
Stroke
Heart disease
High blood pressure
Psychiatric disorders
Other neurologic diseases

If your parents are alive, what are their ages?

If your parents have died, at what age and from what cause?

9. ALLERGIES TO MEDICATIONS and please note if drug causes rash or difficulty breathing.

10. MEDICATIONS

What are your current medications, include hormones, birth control pills, special diet, etc. (Name and Amount/Day)?

1.
2.
3.
4.
5.
6.
7.
8.

11. HAVE YOU HAD:

	Yes	Result	When
Hearing test			
Evaluation by a neurologist			
Evaluation by an ear doctor			
Evaluation by an eye doctor			
Caloric test (water or air in ear)			
MRI (was dye also given by injection?)			

12. MULTIDIMENSIONAL DIZZINESS INVENTORY: SECTION A

In the last 6 months, what percentage of the time has dizziness interfered with your activities?

Mark Line: |----------|----------|----------|----------|----------|
0% 20% 40% 60% 80% 100%

Instructions. Please answer the following questions about your dizziness and how it affects your life. Read each question and then **circle a number** on the scale under that question to indicate how that question applies to you.

1. Rate the level of your dizziness at the present moment.

1	2	3	4	5
none	slight	moderate	quite a bit	extreme

2. Since the time your dizziness began, how much has your dizziness changed your ability to work? (___Check here, if you have retired for reasons other than your dizziness.)

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

3. How much has your dizziness changed your ability to do household chores?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	very much

4. Does your dizziness significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	very much so

5. To what extent does dizziness prevent you from driving your car?

1	2	3	4	5
not at all	slightly	moderately	markedly	severely

MULTIDIMENSIONAL DIZZINESS INVENTORY: SECTION B

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you generally feel this way, that is, how you feel on the average. Use the following scale to record your answers.

1	2	3	4	5
very slightly or not at all	a little	moderately	quite a bit	extremely

_____interested
_____distressed
_____excited
_____upset
_____strong
_____guilty
_____scared
_____irritable
_____alert
_____ashamed
_____inspired
_____nervous
_____determined
_____attentive
_____jittery
_____active
_____afraid
_____hostile
_____enthusiastic
_____proud

The Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?	o Yes o Sometimes o No
E2. Because of your problem, do you feel frustrated?	o Yes o Sometimes o No
F3. Because of your problem, do you restrict your travel for business or recreation?	o Yes o Sometimes o No
P4. Does walking down the aisle of a supermarket increase your problems?	o Yes o Sometimes o No
F5. Because of your problem, do you have difficulty getting into or out of bed?	o Yes o Sometimes o No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	o Yes o Sometimes o No
F7. Because of your problem, do you have difficulty reading?	o Yes o Sometimes o No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	o Yes o Sometimes o No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	o Yes o Sometimes o No
E10. Because of your problem have you been embarrassed in front of others?	o Yes o Sometimes o No
P11. Do quick movements of your head increase your problem?	o Yes o Sometimes o No
F12. Because of your problem, do you avoid heights?	o Yes o Sometimes o No
P13. Does turning over in bed increase your problem?	o Yes o Sometimes o No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	o Yes o Sometimes o No
E15. Because of your problem, are you afraid people may think you are intoxicated?	o Yes o Sometimes o No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	o Yes o Sometimes o No
P17. Does walking down a sidewalk increase your problem?	o Yes o Sometimes o No
E18.Because of your problem, is it difficult for you to concentrate	o Yes o Sometimes o No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	o Yes o Sometimes o No

E20. Because of your problem, are you afraid to stay home alone?	o Yes o Sometimes o No
E21. Because of your problem, do you feel handicapped?	o Yes o Sometimes o No
E22. Has the problem placed stress on your relationships with members of your family or friends?	o Yes o Sometimes o No
E23. Because of your problem, are you depressed?	o Yes o Sometimes o No
F24. Does your problem interfere with your job or household responsibilities?	o Yes o Sometimes o No
P25. Does bending over increase your problem?	o Yes o Sometimes o No

The Activities-specific Balance Confidence (ABC) Scale

For <u>each</u> of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100%

<u>no confidence</u> **<u>completely confident</u>**

"How confident are you that you will <u>not</u> lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes and reach for something above your head? ____%
6. …stand on a chair and reach for something? ____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? ____%
10. …walk across a parking lot to the mall? ____%
11. …walk up or down a ramp? ____%
12. …walk in a crowded mall where people rapidly walk past you? ____%
13. …are bumped into by people as you walk through the mall?____%
14. … step onto or off an escalator while you are holding onto a railing? ____%
15. … step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. …walk outside on icy sidewalks? ____%