kintsugi PHYSICAL THERAPY & WELLNESS	**VESTIBULAR INTIAL QUESTIONAIRE AND MEDICAL HISTORY**	Name:
		Age:
		Date:

What is the reason for your visit today?				
Date of onset symptoms:				
Which of the following best describes how your symptoms started? Circle all that apply.				
Fall	Trauma	MVA	Unknown	Other:
Are your symptoms the result of a work injury?	YES NO			
Please indicate the sensations that you have been experiencing. Circle all that apply.				
Spinning	Visual disturbances	Imbalance	Ringing in ears	
Nausea	Vomiting	Hearing loss	Difficulty focusing	
Falls/Loss of balance	Lightheadedness			
What symptoms are you experiencing at this moment?				
Dizziness intensity on scale of 0 to 10	_____ 0 = no dizziness, 10 = need to go to ER			
Is your dizziness: (circle one)	constant or intermittent			
Is your dizziness: (circle one)	spontaneous provoked by movement/environment			
How long do your dizziness episode last?				
What aggravates your symptoms? Circle all that apply.				
Elevators	Shopping	Walking	Driving	
Unstable surfaces	Bending	Walking in the dark	Reacting	
Turning				
What relives your symptoms?				
What activities at home, work or recreational are you unable to perform because of your symptoms?				
Please state below any executive function difficulties you may be having: (i.e. memory loss, organization, speech, etc.)				
Since the onset of your current symptoms, have you experienced and of the below? Circle all that apply.				
Abdominal pain	Dizziness/Lightheadedness	Hear burn / indigestion	Persistent cough	
Bowel/Bladder changes	Fainting	Muscle weakness	Recent infection	
Difficulty swallowing	Fever/Chills/Sweats	Nausea/Vomiting	Unexplained weight loss	
Difficulty walking	Headaches	Night pain	Vision changes	
Have you had any of the below test for this condition?				
VNG CT Scan. Hearing. MRI. Other: _____ Test Results here if known:				
Please indicate any previous or current treatment you have had related to your current injury. Circle all that apply.				
Chiropractic/Osteopath. Physical Therapy. Medication. None. Other: _____				
Have you had any previous injuries to the head or neck?	NO YES_____			
Do you have a history of ear/sinus infections as a child?	NO YES			
Do you have motion sensitivity?	NO YES			
Have you had a recent cold or infection?	NO YES			
Are you experiencing any pain anywhere? If yes, rate your pain on a scale of 0 – 10. 0 = no pain, 10 = Emergency	NO YES: _____/10 Location of pain: _____			

PLEASE COMPLETE THE OTHER SIDE

WORK HISTORY			
Are you currently employed?	YES NO. Retired. Student		
Occupation:			
If injured on the job or with is affected by your current symptoms, please fill out the next three sections.			
Are you currently working?	YES/Full duty. YES/Light duty. NO/Last day of duty		
Are you planning to return to your job of injury?	YES NO. Unsure		
If no, has an alternate job goal been identified for you?	NO/I don't know Yes, the new goal is:		
MEDICAL HISTORY			
At the present time, would you say that your health is:	Excellent Good Fair Poor		
Please indicate if you have had any prior injuries to the following joints. Circle all that apply.			
Ankle Back Elbow Foot Hand Hip Knee Neck Shoulder			
Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply.			
Allergies	Face/Ear/Jaw pain	Kidney disease	Pregnant (currently)
Anemia	Fibromyalgia	Latex of tape allergy	Rheumatoid arthritis
Asthma	Gout	Liver disease	Shortness of breath
Back/Neck pain	Heart Disease	Migraines	Skin Condition
Blood clots	Hepatitis	Multiple Sclerosis	Stroke / TIA
Cancer	Hernia	Osteoarthritis	Swelling in the feet /legs
Chest pain	Hight blood pressure	Osteoporosis	Thyroid issues
Depression	HIV+/AIDs	Pacemaker	Tuberculosis
Diabetes	Imbalance	Parkinson's	
Epilepsy / Seizures	Incontinence	Polio	
Please list and other medical conditions we should know about:			
Please list and surgeries you have had:			
Have you had any major illnesses/hospitalizations in the last year? YES NO If yes, please describe below:			
MEDICATIONS: Please list all medications you are taking including dosage, frequency, and route to administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability, If you have a list, please give it to our of front office so that they may make a copy. [ ] Please see attached list. [ ] I am not taking any medications, vitamins, or supplements.			
Name	Dosage	Frequency	Route of Administration
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
Have you had any falls in the last 12 months?		YES NO	
If yes, how many?		Did you injure yourself in any of those falls?	YES NO
Do you currently use any type of tobacco products?			

_____ _____

Patient or Guardian Signature Date

For office use only: Heart rate_____ Blood Pressure_____ Taken by:_____