Rehabilitation Services Concussion and Vestibular Intake

Welcome! Please fill this out to the best of your ability and return it to the front desk. Thank you!

1. **Please rate your dizziness over the last few days on a scale of 0-10. 0 = no dizziness 10 = worst dizziness imaginable.** You may indicate a range, for example, 0-3/10.

   _____ **/ 10**

2. **How many days per week are you experiencing symptoms?** _____

3. **Please check all symptoms you are experiencing:**

   ☐ Dizziness
   ☐ Light Headedness
   ☐ Loss of Balance
   ☐ Fullness or Pressure in the Ears
   ☐ Fogginess
   ☐ Ringing in the Ears
   ☐ Memory Problems
   ☐ Sensitivity to Noise
   ☐ Nausea
   ☐ Sensitivity to Light

4. **Do you experience a spinning sensation, or feel as though the room is spinning around you?** ☐ Yes ☐ No

   a. If so, how long does the spinning last? _____

   b. When was the last time it occurred? _____

5. **Do you have symptoms when rolling in bed?** ☐ Yes ☐ No

6. **Do you have symptoms when getting out of bed?** ☐ Yes ☐ No

7. **Please check all of the following activities that increase your symptoms:**

   ☐ Fatigue
   ☐ Walking
   ☐ Busy Environments
   ☐ Riding in a Car
   ☐ Sitting
   ☐ Reading
   ☐ Standing
   ☐ Computer/Phone Use

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8. **Are you taking any medications for your dizziness?** ☐ Yes ☐ No
   a. If so, please list the medication(s) here: _____

_____

_____

9. **Do you have a history of any of the following diagnoses?** (Please check all that apply.)

☐ Neck Pain	☐ Meniere's Disease
☐ Neck Surgery	☐ Concussion
☐ Migraines	☐ Stroke (CVA)

10. **Have you fallen in the past month?** ☐ Yes ☐ No
    a. If Yes, how many falls have you had in the past month? _____
    b. How did the fall(s) happen? _____

_____

_____

_____

_____

_____

_____

_____

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Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate your answer by circling "Yes" **OR** "No" **OR** "Sometimes" for each question. **Answer each question as it pertains to your dizziness or unsteadiness problem only**. **Please do not skip any questions.**

P1.	Does looking up increase your problem?	Yes	Sometimes	No
E2.	Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or parties?	Yes	Sometimes	No
F7.	Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8.	Does performing more ambitious activities like sports, dancing, and household chores (such as sweeping or putting away dishes) increase your problem?	Yes	Sometimes	No
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	Sometimes	No
E10.	Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P11.	Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12.	Because of your problem, do you avoid heights?	Yes	Sometimes	No
P13.	Does turning over in bed increase your problem?	Yes	Sometimes	No

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F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15.	Because of your problem, are you afraid people might think that you are intoxicated?	Yes	Sometimes	No
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17.	Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18.	Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19.	Because of your problem, is it difficult for you to walk around the house in the dark?	Yes	Sometimes	No
E20.	Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21.	Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes	Sometimes	No
E23.	Because of your problem, are you depressed?	Yes	Sometimes	No
E23.	Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P25.	Does bending over increase your problem?	Yes	Sometimes	No

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	Yes	Sometimes	No	Total
Physical (7)	_____ x 4 = _____	_____ x 2 = _____	_____	_____ (28)
Emotional (9)	_____ x 4 = _____	_____ x 2 = _____	_____	_____ (36)
Functional (9)	_____ x 4 = _____	_____ x 2 = _____	_____	_____ (36)

Total _____ / 100

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Start of symptoms: _____

Reason for visit (pain, balance, etc.): _____

Height: _____ Weight: _____ Occupation: _____

Gender: _____ Pronouns (circle): She/Her He/Him They/Them Other

What do you do in your free time/what are your hobbies? _____

_____

What is a realistic goal that you would like to achieve with therapy? _____

_____

Is there anything else you would like for us to be aware of? _____

_____

We want to know **your goals** to help us guide your care. Please list three important activities below that you are currently having difficulty with or cannot do.	**0** = **Unable** to perform the activity										**10** = **Able** to perform the activity at the same level as before the injury or problem
What activities do you have difficulty with because of your injury or problem? Please list below and mark your current rating.	**CURRENT RATING**										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.											
2.											
3.											

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Please check any symptoms that you are currently experiencing:

- ☐ Fever/Chills/Sweats
- ☐ Poor balance (falls)
- ☐ Unexplained weight loss
- ☐ Numbness or Tingling
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Depression
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Increased pain at night
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Difficulty concentrating/thinking
- ☐ Changes in bladder or bowel function

Please check any medical or surgical history we should be aware of:

- ☐ Arthritis
- ☐ Heart Condition
- ☐ Spinal Cord Injury
- ☐ Blood Clots
- ☐ Hernia
- ☐ Stroke/TIA
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Vision Problems
- ☐ Diabetes
- ☐ Kidney Disease/Dialysis
- ☐ Memory Problems
- ☐ Drug-Resistant Infection
- ☐ Liver disease/Hepatitis
- ☐ Other: _____
- ☐ Epilepsy/Seizures
- ☐ Lymphedema
- Are you pregnant/nursing? ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- Do you smoke? ☐ Yes ☐ No

Are you allergic to latex and/or adhesives? ☐ Yes ☐ No

Have you received any other therapy or alternative care treatments this calendar year?

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Chiropractic Treatment ☐ Acupuncture ☐ Massage Therapy

How many visits did you have?: _____ Clinic Name: _____

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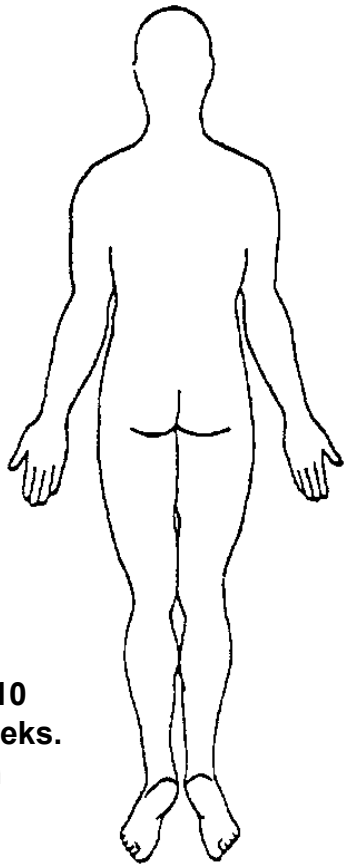
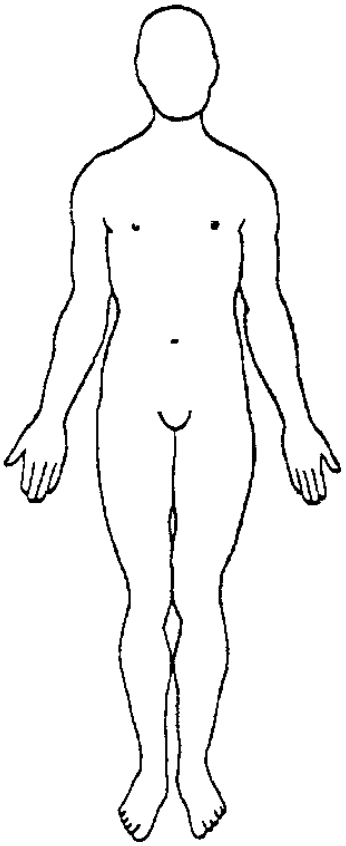
Body Chart:

On the body diagrams below, please mark the areas where you have symptoms.

(Left) – **Back** – (Right)



(Right) – **Front** – (Left)



Circle all that apply:

Shooting/sharp pain

Dull/aching pain

Numbness

Tingling

My Symptoms Currently:

☐ Come and go

☐ Are constant

☐ Are constant, but change with activity

Please rate your pain from 0 – 10 over the last couple of days/weeks. 0 = no pain, 10 = the worst pain imaginable.

My Pain Currently: _____

My Pain At Its Lowest: _____

My Pain At Its Highest: _____

My symptoms are worse with: _____

My symptoms are better with: _____

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