ADVANCED PHYSICAL THERAPY OF VIRGINIA, INC.
VESTIBULAR PATIENT HEALTH QUESTIONNAIRE

Name:_____ DOB:_____ Age:_____
Sex M / F Height:_____ Weight:_____ Right/Left Handed Children:_____ Do you smoke? Y/N
Occupation:_____ Currently Working Y/N Do you live alone? Y/N
Does your home have (circle): stairs no railing/stairs with railing/ramp/uneven terrain/assistive devices
Do you use (circle): cane/walker/manual wheelchair/motorized wheelchair/glasses/hearing aids
Please rate your health: ___Excellent ___Very Good ___Good ___Fair ___Poor
Have you had any major life changes during the past year? (e.g. new baby, job change, death of family, etc) Y/N
Are you currently pregnant? Y/N
ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? ___YES ___NO
Family History: Please list any pertinent family history (e.g. heart disease, stroke, diabetes, cancer, etc.)
_____

Medical/Surgical History Please check if you have ever had:

___Arthritis	___Muscular Dystrophy	___Multiple Sclerosis
___Broken bones/fractures	___Parkinson Disease	___Head injury
___Osteoporosis	___Seizures/epilepsy	___Stroke
___Blood disorder	___Kidney Problems	___Depression
___Circulation/vascular problems	___Developmental/Growth Problems	___Thyroid Problems
___Heart problems/Pacemaker	___Cancer (type)_____	___Repeated Infections
___High blood pressure	___Allergies (Latex sensitivity Y/N)	___Lung problems
___Low blood sugar/hypoglycemia	___Ulcers/Stomach Problems	
___Diabetes/high blood sugar	___Infectious disease (e.g. tuberculosis, hepatitis)	
___Repeated Infections	___Other: _____	

Within the past year, have you had any of the following symptoms? (check all that apply)

___Chest pain	___Difficulty sleeping	___Pain at night
___Heart palpitations	___Loss of appetite	___Joint pain or swelling
___Cough	___Nausea/vomiting	___Vision problems
___Hoarseness	___Difficulty swallowing	___Hearing problems
___Shortness of breath	___Bowel problems	___Headaches
___Dizziness or blackouts	___Unexplained weight loss/gain	___Difficulty walking
___Coordination problems	___Urinary problems	___Loss of balance
___Weakness in arms or legs	___Fever/chills/sweats	___Other:_____

Have you ever had surgery? Y/N If yes, please indicate type(s) and date(s) of surgery: _____
_____

Medications:_____

Special Tests (related to your current problem):_____

Audiology History:

Y/N Do you have trouble hearing? ___Right ___Left ___Both

Y/N Do you seem to hear any noises (e.g. buzzing, ringing, popping, roaring)? ___Right ___Left ___Both

Y/N Have you noticed a fullness/pressure or stiffness in your ears? ___Right ___Left ___Both

Y/N Have you noticed any pain in your ears? ___Right ___Left ___Both

Vestibular History:

Y/N Have you suffered with dizziness or unsteadiness? If so, how would you described your dizziness? Please circle all that apply:

Light headedness Clumsiness Nausea Staggering Motion Intolerance Spinning
Rocking or Swaying Blacking out "Heavy headedness"

Y/N Does any movement or change in head position make the dizziness worse?

Please describe:_____

Y/N Does your dizziness or unsteadiness come in attacks? If so, please describe:

When was the first attack? _____ How long did it last?_____

When was your last attack? _____ How long did it last?_____

What makes it worse? _____Better?_____

Y/N Are you completely free of dizziness/unsteadiness between attacks?

Y/N Have you had any accidents or bumps to your head?

Y/N Has your dizziness ever caused you to fall? If so, when? _____, How often?_____

Any injuries from falling? Please describe_____

Y/N Any changes in concentration? (ie. difficulty with talking, foggy, memory changes)

Please rate your symptoms on a 0-10 scale (0=no symptoms, 10=emergency room visit):

At best? _____ At worse? _____ Now? _____

Y/N Do you have any pain or stiffness in your neck?

Y/N Do you have any weakness or fatigue?

What position do you sleep in? Stomach, Back, Side R/L How many pillows at your head? _____

Vision History:

Y/N Do you have any trouble with vision: blurry/double/sensitivity to light?

Y/N Do you have any of the following vision conditions: macular degeneration/glaucoma/wear glasses?

Y/N Do you have any symptoms with busy visual stimuli: reading/computer/riding in a car?

Headaches:

Y/N Do you have history of headaches, migraines, sensitivity to light or sound?

Y/N Is your dizziness ever associated with headaches? If so, how long? _____ Location?_____

Sensation:

Y/N Do you have any numbness or tingling sensation? If so, where? _____

What are your goals for treatment?_____

FOR OFFICE USE ONLY

This patient is an **excellent/good/fair/poor** rehabilitation candidate for skilled physical therapy intervention.

Therapist Signature _____ Date_____