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# VESTIBULAR QUESTIONNAIRE

**Name:**________________________________ **Date of Birth:**____/____/____ **Today's Date:**____/____/____

Home phone #:____________ Cellular #:____________ Work phone #:____________ Best # to call? Work / Home / Cell

Are you working? Yes/ No. If no, do you have a job to return to? Yes/ No. What is your occupation?____________

Briefly describe the history of your symptoms:________________________________

____________________________________________________________

____________________________________________________________

What are your symptoms? Dizziness/ Light-headedness/ Room spinning/ Other: ________________

Typically, how long do your symptoms last?______ Seconds/ Minutes/ Hours/ Days/ Weeks/ Other: __________

Please indicate your degree of dizziness:

Dizziness at rest: None ____________________ Severe    With activities: None ____________________ Severe

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

Do you experience headaches? Yes/ No    If "yes" where do you feel the pain? ________________

What makes your symptoms worse? ________________________________

What makes your symptoms better? ________________________________

What exercise/sports/activities do you participate in? ________________________

What activities are you unable to participate in?__________________________

What would you like to do? What are your goals?__________________________

What MD's have you seen for this condition?____________________________

What was the diagnosis and treatment given? ____________________________

Any previous surgery for this condition? Yes___ No ___ If Yes, what surgery did you have?________________

________________________________________ When?________________

Who was your surgeon?____________________ What hospital?____________________

List all previous other operations including dates:____________________________

**History**

Answer with a **Y** (Yes) or **N** (No)

____ Heart Disease ____ Cancer ____ Diabetes ____ Stroke ____ Pacemaker _____ Seizures

____ Fainting Spells ____ High/Low blood pressure ____ Circulatory Condition _____ Hepatitis

____ Bruise easily ____ Are you thirsty often? ____ Do you have shortness of breath?

____ Thyroid condition ____ Kidney or liver disease ____ Pain or tightness in chest?

List all medications you are taking: ________________________________________

________________________________________________________________

Please list any allergies: ________________________________________________

Who is your family physician?

Name: ______________________________

Address: ____________________________

____________________________________

Phone #: ____________________________

May we send office notes: Yes____ No____

How did you learn about Metropolitan Physical Therapy?

Doctor/ Former Patient/ Friend/ Internet/ Yellow Pages/ Other

Name: ______________________________________

Address: ____________________________________

____________________________________________

Phone #: ____________________________________

## PATIENT RESPONSIBILITIES

Metropolitan Physical Therapy will bill your insurance carrier at our contracted rates. You will be responsible for meeting your co-payments, deductibles or co-insurances after each visit, and please be aware of your insurance policy provisions. If we get denied payment for any reason due to provisions, you will be responsible to pay us for the denied visits. If you have any questions, please ask our billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue treatment, you will be responsible for our private fee. There will be an increase of fee if more than one diagnosis is being treated, additional equipment or multiple procedures are used. If this account shall be placed in the hands of an outside attorney for collection, the Responsible Party agrees to pay all costs of collection, including reasonable attorney's fees, not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements. There will be a $60 cancellation fee for appointments that are not cancelled 24 hours in advance. We also ask that if you are going to be late to your appointment, please call to notify us. We are trying our best to accommodate you and your schedule and in order to so we suggest that you book your appointments 4-6 weeks in advance so that you can get the time you want.

*I have read the above and agree to the Terms and Conditions. If under 18 please have a parent/guardian sign.*

Patient Name: ______________________________

Signature: ______________________________ Date: ______________________

# Dizziness Handicap Inventory

Name: ______________________________ DOB: __________________ Date: ____________

**Instructions:** The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no" or "sometimes" to each question.
*Answer each question as it applies to your dizziness or unsteadiness only.*

| ITEM | QUESTION | | Y | N | S |
|---|---|---|---|---|---|
| 1 | Does looking up increase your problem? | P | | | |
| 2 | Because of your problem, do you feel frustrated? | E | | | |
| 3 | Because of your problem, do you restrict your travel for business or recreation? | F | | | |
| 4 | Does walking down the aisle of a supermarket increase your problem? | P | | | |
| 5 | Because of your problem, do you have difficulty getting into or out of bed? | F | | | |
| 6 | Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties? | F | | | |
| 7 | Because of your problem, do you have difficulty reading? | F | | | |
| 8 | Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem? | P | | | |
| 9 | Because of your problem, are your afraid to leave your home without having someone accompany you? | E | | | |
| 10 | Because of your problem, are you embarrassed in front of others? | E | | | |
| 11 | Do quick movements of your head increase your problem? | P | | | |
| 12 | Because of your problem, do you avoid heights? | F | | | |
| 13 | Does turning over in bed increase your problem? | P | | | |
| 14 | Because of your problem, is it difficult for you to do strenuous housework or yard work? | F | | | |
| 15 | Because of your problem, are you afraid people may think you are intoxicated? | E | | | |
| 16 | Because of your problem, is it difficult for you to walk by yourself? | F | | | |
| 17 | Does walking down a sidewalk increase your problem? | P | | | |
| 18 | Because of your problem, is it difficult for you to concentrate? | E | | | |
| 19 | Because of your problem, is it difficult for you to walk around the house in the dark? | F | | | |
| 20 | Because of your problem, are you afraid to stay at home alone? | E | | | |
| 21 | Because of your problem, do you feel handicapped? | E | | | |
| 22 | Has your problem placed stress on your relationship with members of your family or friends? | E | | | |
| 23 | Because of your problem, are you depressed? | E | | | |
| 24 | Does your problem interfere with your job or household responsibilities? | F | | | |
| 25 | Does bending over increase your problem? | P | | | |
| | | | x 4 | x 0 | x 2 |
| | | = | | | |
| | | TOTAL | | | |

P ________________ E ________________ F ________________

100-70= severe perception of having a handicap, 69-40= moderate perception of handicap, 39-0= low perception of handicap