Vestibular/Concussion/Imbalance Intake Form

Name:_____ **Date:**_____

Do you exercise? If so, please describe: _____

Primary Concern:
Date of Onset:_____

Describe the problem that brings you to therapy: _____

_____

History of falls? No Yes If yes how often?_____When was last fall/what happened?_____

How often do symptoms occur? Daily Weekly Constantly

How long do symptoms last? Seconds Minutes Hours Days

Since then, has your problem: Worsened ☐ Improved ☐ Same ☐

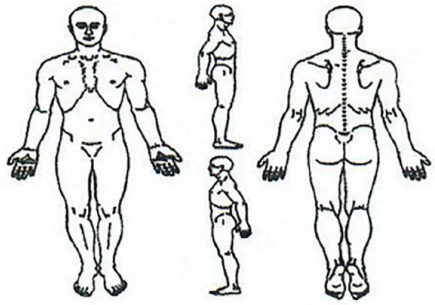
Have you experienced a recent trauma? No ☐ Yes ☐ If yes describe _____

Have you been ill recently (cold, flu, ear infection)? No Yes If yes, please describe:_____

Have you ever experienced this problem before? No ☐ Yes ☐ If yes, please describe:_____

Pain/Dizziness (circle one): If you have no pain, please mark as 0.

If you are having pain, please rate the severity on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:											
At Worst	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10



Symptoms:

Symptom Description (circle all that apply):

Spinning	☐	Rocking/Swaying	☐	Nausea/Vomiting	☐	Balance difficulty	☐
Light Headedness	☐	Ringing in ears	☐	Hearing loss	☐	Ear fullness/ pressure	☐
Headaches	☐	Decreased concentration	☐	Short term memory loss	☐	Long term memory loss	☐
Light sensitivity	☐	Double vision	☐	Objects appear distorted	☐	Sensitivity to motion/vision	☐
Disorientation	☐	Neck pain	☐	Back pain	☐	Facial numbness	☐
Passing out/ fainting	☐	Fatigue	☐	Weakness	☐	Other:	☐

Symptoms increase with (circle all that apply):

Sit to stand	☐	Turn head	☐	Walking	☐	Bending/ Squatting	☐
Lying to sit	☐	Look up/down	☐	Crowds	☐	Cough/ Sneeze	☐
Reading	☐	Rolling in bed	☐				
Driving	☐	Bearing down/ straining	☐				

Other (please list): _____

_____ _____

Patient/Guardian Signature **Date**

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

Scoring for Dizziness Handicap Inventory

Eval	Total Functional	Total Emotional	Total Physical	TOTAL SCORE
Reassess #1				
Reassess #2				
Reassess #3				
Reassess #4				

Always = 4

Sometimes = 2

No = 0

P = physical

E = emotional

F = functional

Subscales

Notes:

1. **Subjective measure of the patient's perception of handicap due to the dizziness**
2. **Top score is 100 (maximum perceived disability)**
3. **Bottom score is 0 (no perceived disability)**
4. **The following 5 items can be useful in predicting BPPV**
   - **Does looking up increase your problem?**
   - **Because of your problem, do you have difficulty getting into or out of bed?**
   - **Do quick movements of your head increase your problem?**
   - **Does bending over increase your problem?**
5. **Can use subscale scores to track change as well**