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 ☐

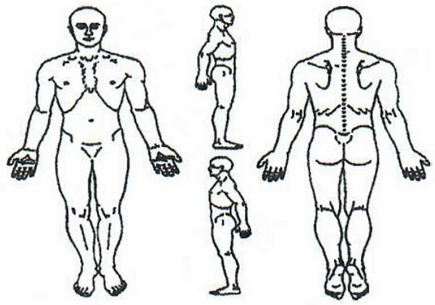
Have you experienced a recent trauma? No ☐ Yes ☐ If yes describe _____

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 ☐	Reading ☐	Rolling in bed ☐
Lying to sit ☐	Look up/down ☐	Crowds ☐	Cough/ Sneeze ☐	Driving ☐	Bearing down/ straining ☐

Other (please list): _____

_____ _____

Patient/Guardian Signature **Date**