EQUILIBRIUM
Balance Performance Center

PATIENT'S NAME: ______________________________ TODAY'S DATE: ______________
First MI Last

SSN# __________________ DOB ______________ AGE ____ SEX: M ☐ F ☐

ADDRESS ____ APT# __________

CITY ______________________ STATE _____________ ZIP _________ - ______

HOME PHONE (____) _____-________ CELL PHONE (____) _____-________

WORK PHONE (____) _____-________ *E-MAIL ADDRESS ______________________
*(PLEASE COMPLETE – appointment confirmations will be sent by email)

SPOUSE'S NAME: ______________________________ PHONE (____) _____-________
First MI Last

EMERGENCY CONTACT NAME: ____________________ RELATIONSHIP TO PATIENT: ______________

PHONE (____) _____-________ CHECK ONE: ☐ OFFICE ☐ HOME ☐ CELL ☐ OTHER

*REFERRING PHYSICIAN: ______________________________ PHONE (____) _____-________
ADDRESS _____________________ CITY _____________ STATE ____ ZIP ______-_____

*PRIMARY PHYSICIAN: ______________________________ PHONE (____) _____-________
ADDRESS _____________________ CITY _____________ STATE ____ ZIP ______-_____

☐ Please send my primary physician a copy of my Physical Therapy evaluation report.

NEUROLOGIST: ______________________ ☐ Please send this doctor a copy of my evaluation

EAR NOSE & THROAT (ENT): ______________________ ☐ Please send this doctor a copy of my evaluation

CARDIOLOGIST: ______________________ ☐ Please send this doctor a copy of my evaluation

PRIMARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION IN FULL; WE WILL COPY FRONT / BACK OF INSURANCE CARD)

INSURANCE CO ____

* PRIMARY POLICY HOLDER'S NAME ____________________________ SSN# ________________

DOB _______________ EMPLOYER ____

ADDRESS _________________________ CITY ______________ STATE ____ ZIP _______-______

HOME PHONE (_____) ______-________ CELL PHONE (_____) ______-________

WORK PHONE (_____) ______-________ E-MAIL ADDRESS ____________________

SECONDARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION IN FULL; WE WILL COPY FRONT / BACK OF INSURANCE CARD)

INSURANCE CO ____

*** PRIMARY POLICY HOLDER'S NAME** ______________________ **SSN#** ______________

DOB ____________ **EMPLOYER** ______________________________

ADDRESS ____________________ **CITY** __________ **STATE** ____ **ZIP** ______-_____

HOME PHONE (_____) ______-_________ **CELL PHONE** (_____) ______-_________

WORK PHONE (_____) ______-_________ **E-MAIL ADDRESS** ____________________

(IF THE PATIENT IS A MINOR)

MOTHER'S NAME ____________________ **FATHER'S NAME** ____________________

SSN# ____________________ **SSN#** ____________________

EMPLOYER ____________________ **EMPLOYER** ____________________

PHONE (_______) ________-________________ **PHONE** (_______) ________-________________

OCCUPATION ____________________ **OCCUPATION** ____________________

RELEASE OF MEDICAL INFORMATION _________ **initials**

I authorize EQUILIBRIUM Balance Performance Center, PT, Inc to release medical records concerning my self / son / daughter / other dependent to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS _________ **initials**

I authorize my insurance carrier to assign medical benefits to EQUILIBRIUM Balance Performance Center, PT, Inc. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY _________ **initials**

Co-payments are due at the time services are received. We accept cash and check only at this time. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility / non-payable / non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELATION POLICY _________ **initials**

Our office requires that if an appointment needs to be cancelled, we receive notice **no later than 5pm on the previous business day** prior to your scheduled appointment. Please note, our business days are Tuesday through Friday. Cancellations for Tuesday must be received by 5PM on the preceding Friday. Cancellations and no show fees are the patient's responsibility and will not be billed to your insurance. Fee payments are due on or before your next appointment. **I, the patient, agree to pay a $50.00 fee for each** late **cancellation and no show appointment**.

REFERRAL POLICY _________ **initials**

I understand it is my responsibility to obtain a prescription from my referring physician's office to receive therapy services. Failure to do so will result in charges being billed in full directly to myself. In addition, all therapy services will be placed on hold until the physician's prescription for therapy services is received.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES AND CLINIC POLICIES:

X ________________________________ X ______________________

SIGNATURE OF RESPONSIBLE PARTY **DATE READ AND SIGNED**

VESTIBULAR AND BALANCE REHABILITATION QUESTIONNAIRE

DIAGNOSIS: (reason you are here):______________________________

Are you currently being seen by any of the following?

☐ Physical Therapist ☐ Speech Therapist ☐ Occupational Therapist ☐ Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason:______________________________

Have you had therapy for current symptoms? ☐ Yes ☐ No

If you answered yes, please explain where and when, and the outcome of the therapy: ______________________________

____

MEDICAL HISTORY: Have you had or do you suffer from: (Check all that apply)

☐ High blood pressure ***OR*** ☐ Low blood pressure
☐ Heart problems ______________________________
☐ Diabetes
☐ Stroke/Neurological
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Seizures/Convulsions
☐ Kidney disease
☐ Cancer
☐ Life threatening infection
☐ Cardiac/heart disease
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ Depression
☐ Do you drink alcohol? ☐ Yes ☐ No how much?_________ Use tobacco? ☐Yes ☐ No packs/day_____
☐ Use recreational drugs? Have a dependency on prescription drugs? ☐ Yes ☐ No how much?_________
☐ Recent flu/Virus (please specify):______________________________

☐ **Orthopedic conditions** – ***(please list)*** ______________________________

____

____

____

____

CURRENT **SYMPTOMS INITIAL ONSET / EXACERBATION DATE:** ____ / ____ / ______

PRIMARY SYMPTOMS: **(check all that apply)**

☐ imbalance

☐ dizziness ☐ recent ☐ past

☐ vertigo (Sensation of spinning) ☐ recent ☐ past ☐ Family history of vertigo?

☐ lightheaded ☐ spaciness ☐ Motion sickness

☐ nausea ☐ vomiting ☐ Pressure in your head

SEVERITY OF SYMPTOMS: (rated 0-10) **Dizziness _____ / 10** **Imbalance _____ / 10**

WHAT CAUSED YOUR SYMPTOMS TO ONSET: ______________________________

____

MEDICAL HISTORY RELATED TO YOUR CURRENT SYMPTOMS: ____

____

____

Do you or have you had (Check all that apply below):

☐ Trauma or blow to the head

☐ Loss of consciousness

☐ Ear infections (please specify): ☐ recent ☐ past ☐ childhood

☐ Headaches (please specify): ☐ recent ☐ past ☐ childhood

☐ Migraines ☐ recent ☐ past ☐ childhood

☐ Vision: ☐ blurry vision ☐ double vision

☐ glaucoma ☐ cataracts R-L ☐ other:______________________________

Corrected with: ☐ surgery ☐ lenses monofocal – bifocal – trifocal

	Right	Left	Both
☐ Have you had any recent changes in your ears?			
☐ Distortion in hearing?	☐	☐	☐
☐ Difficulty hearing?	☐	☐	☐
☐ Pressure/pain in your ears?	☐	☐	☐
☐ Drainage / daischarge from your ears?	☐	☐	☐
☐ Tinnitus (Noise in your ears)?	☐	☐	☐

Describe:_____________________________________

☐ Neck Pain

☐ Recent inner ear infection(s)

☐ CVA

☐ TIA

☐ Sinus problems

☐ Recent sudden memory loss

VERTIGO / DIZZNESS (NATURE of SYMPTOMS) ONSET:

☐ gradually ☐ suddenly
☐ with warning ☐ without warning

☐ in spells / episodes *(If spells) when was your ast severe spell?: ____________________

How often do they occur? ____

How long do they last? ☐ < 1min / seconds ☐ Hours

☐ > 1min. / minutes ☐ Days

Are there symptoms between attacks? ☐ Yes ☐ No

SYMPTOM TREND SINCE ONSET: ☐ better ☐ worse ☐ no change

WHAT AGGRAVATES YOUR SYMPTOMS?: ____

CIRCUMSTANCES THAT MAY CAUSE / INCREASE SYMPTOMS:

☐ laying to sitting ☐ sit to stand ☐ lying down turning over in bed ☐ R ☐ L

☐ elevators ☐ bending forward ☐ quick head / body movement

☐ riding in a car ☐ blowing your nose ☐ busy public environments
☐ loud noises ☐ bright lights ☐ ↑ abdominal pressure

HISTORY OF FALLS: ☐ **Y** ☐ **N** **If yes, date of last fall ____ / ____ / ______**

# of falls in the last month _____ week _____

Explain: ____

DO YOU LOOSE YOUR BALANCE / STUMBLE? ☐ **Y** ☐ **N**

HOW OFTEN? ______________________________

WHICH DIRECTION DO YOU FALL TOWARD? ☐ Right ☐ Left ☐ Back ☐ Front

RESULTS OF IMAGING TESTS:

☐ **MRI ______________________________**
☐ **CT SCAN ______________________________**
☐ **MRA ____________________ or DOPPLER ____________________** (for carotid and/or vertebral artery testing)

RESULTS OF VESTIBULAR TESTS:

☐ **VNG / CALORICS ______________________________**
☐ **ROTATIONAL CHAIR ______________________________**
☐ **HEARING ______________________________**
OTHER ______________________________

CURRENT LEVEL of FUNCTION:

ACTIVITIES RESTRICTED DUE TO CONDITION: ______________________________

(Please mark the areas where you have seen a decline in your abilities since the onset of your symptoms):

☐ Getting in or out of bed ☐ Getting in or out of chairs ☐ Walking/Balance
☐ Eating ☐ Dressing ☐ Grooming
☐ Lifting ☐ Bending ☐ Going to church
☐ Going to malls / being in crowds ☐ Driving a car ☐ Being a passenger in a car
☐ Do you find yourself more tired/fatigued? ☐ Other:____________________

PREVIOUS LEVEL of FUNCTION:

____

____

____

MEDICAL RED FLAGS:

HAVE YOU HAD A *RECENT / SUDDEN* ONSET OF ANY OF THE FOLLOWING?:

☐ **difficulty with bowel or bladder function** ☐ **genital/anal area numbness**
☐ **numbness (hands, feet, mouth, or face)** ☐ **fever/chills**
☐ **unexplained or sudden weakness** ☐ **dizziness / fainting attacks**
☐ **unexplained or sudden weight change** ☐ **night pain / sweats**
☐ **malaise (unusual fatigue / listlessness)** ☐ **difficulty speaking**
☐ **unexplained or sudden vision / hearing problem onset / changes**

MEDICATION

Are you currently taking any medication for your dizziness or vertigo? ________________________________

SELF ASSESSMENT

Dizziness Handicap Inventory

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. **Please answer all the questions in the questionnaire; this will help ensure an accurate evaluation.**

Key: Y = Yes N = No S = Sometimes

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 in/out of bed?	**F**	☐	☐	☐
6.	Does your problem significantly restrict your participation social acticities?	**F**	☐	☐	☐
7.	Because of your problem, do you have difficulty reading?	**F**	☐	☐	☐
8.	Does performing more ambitious activities increase your problem?	**P**	☐	☐	☐
9.	Because of your problem, are you afraid to leave home without someone accompanying 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.	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?	**E**	☐	☐	☐
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 your house in the dark?	**F**	☐	☐	☐
20.	Because of your problem, are you afraid to stay home alone?	**E**	☐	☐	☐
21.	Because of your problem, do you feel handicapped?	**E**	☐	☐	☐
22.	Has your problem placed stress on your relationships 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**	☐	☐	☐

CLINICIAN USE ONLY

		Sub Total	___	___	___	
			x4	x0	x2	
P ____	**E** ____	**F** ____ **Total**	___	___	___	= ___

The Activities-specific Balance Confidence (ABC) Scale

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0%	10	20	30	40	50	60	70	80	90	100%
no confidence										**completely confident**

"How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to the car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy (slippery) sidewalks? _____%

CLINICIAN USE ONLY

TOTAL _____%