EQUILIBRIUM
PHYSICAL THERAPY

PATIENT'S NAME: _____ **DATE:** _____
First MI Last

SSN# _____ **DOB** _____ **AGE** _____ **SEX: M** ☐ **F** ☐

ADDRESS _____ **APT#** _____

CITY _____ **STATE** _____ **ZIP** _____ - _____

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

WORK PHONE (____) _____-_____ **EMPLOYER:** _____

PROFESSION: _____ **RETIRED? : Y** ☐ **N** ☐

***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

Are you currently being seen by any of the following?
☐ Physical Therapist ☐ Speech Therapist ☐ Occupational Therapist ☐ Psychiatrist/Psychologist ☐ Home Health Care

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: _____

Worker's Compensation Only: Date of Injury: _____ Please provide a brief description of your injury: _____

_____

PRIMARY INSURANCE INFORMATION

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

INSURANCE CO _____ **Member ID:** _____ **Group #:** _____

* **PRIMARY POLICY HOLDER'S NAME** _____ **DOB** _____

SECONDARY INSURANCE INFORMATION

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

INSURANCE CO _____ **Member ID:** _____ **Group #:** _____

* **PRIMARY POLICY HOLDER'S NAME** _____ **DOB** _____

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, check, credit and debit cards. 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 Monday through Friday. Cancellations for Monday 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**

PATIENT'S NAME: _____ **DATE:** _____
First **MI** **Last**

VESTIBULAR AND BALANCE REHABILITATION QUESTIONNAIRE

DIAGNOSIS: (reason you are here): _____

Date of Onset / Exacerbation: ____ / ____ / _____

What caused your current symptoms: _____

CURRENT / PRIMARY SYMPTOMS: (check all that apply)

- ☐ Imbalance / Staggering
- ☐ Trouble walking
- ☐ Sense of leaning/tilting
- ☐ Dizziness
- ☐ Vertigo (Sensation of spinning)
- ☐ Lightheaded/ floating sensation
- ☐ Nausea/vomiting
- ☐ Disorientation / spaciness
- ☐ Undulations (like on a boat)
- ☐ Motion sickness
- ☐ Head congestion/pressure
- ☐ Headaches
- ☐ Migraines
- ☐ Neck pain
- ☐ Pain / Pressure in ears **(CIRCLE)**
- ☐ Discharge from ears
- ☐ Ringing in ears/tinnitus
- ☐ Hearing loss
- ☐ Blurry vision
- ☐ Jumpy vision
- ☐ Double Vision
- ☐ Visual confusion
- ☐ Visual loss: _____
- ☐ Facial numbness / pain **(CIRCLE)**
- ☐ Poor memory/concentration
- ☐ Weakness
- ☐ Fatigue

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

- ☐ High ***OR*** Low blood pressure **(PLEASE CIRCLE ONE)**
- ☐ Heart problems: _____
- ☐ Diabetes
- ☐ Stroke/Neurological
- ☐ TIA "mini stroke"
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Parkinson's Syndrome
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis (autoimmune)
- ☐ Osteoarthritis
- ☐ Osteoporosis / Osteopenia **(PLEASE CIRCLE ONE)**
- ☐ Kidney disease
- ☐ Cancer
- ☐ Tumor _____ ☐ removed?
- ☐ Life threatening infection
- ☐ Sinus problems
- ☐ Head trauma/ concussion **(PLEASE DESCRIBE BELOW)**

_____
_____

Do you smoke? ☐ **Y** ☐ **N** Packs / day: _____

- ☐ Inner ear infections
- ☐ History of swimmers ear
- ☐ Punctured eardrum
- ☐ Ear drum surgically resected
- ☐ Peripheral neuropathy
- ☐ Cataracts ☐ removed? **DATE:** _____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Degeneration
- ☐ Detached Retina ☐ repaired? **DATE:** _____
- ☐ Astigmatism
- ☐ Sudden memory loss
- ☐ Panic attacks/anxiety
- ☐ Depression
- ☐ Orthopedic / Musculoskeletal problems / surgeries **(PLEASE LIST BELOW)**

_____
_____
_____
_____

Do you drink? ☐ **Y** ☐ **N**
Drinks / day:___ week:___ month:__

SEVERITY OF SYMPTOMS (AVERAGE): (rated 0-10) Dizziness _____ / 10 **Constant? Y / N**

Balance Deficit _____ / 10

VERTIGO (SPINNING EVENTS ONLY PLEASE) SYMPTOMS ONSET:

☐ Gradually / with warning ☐ suddenly / without warning
☐ In spells / episodes *(If spells) when was your last severe spell? _____
How often do they occur? _____
How long do they last? ☐ < 1min / seconds ☐ Hours
☐ > 1min. / minutes ☐ Days
Do you have dizziness between episodes? ☐ Yes ☐ No
Do you have any warning signs that an episode is about to happen? ☐ Yes ☐ No

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

CIRCUMSTANCES THAT MAY CAUSE / INCREASE SYMPTOMS:

☐ laying to sitting	☐ sit to stand	☐ lying down turning over in bed ☐ R ☐ L
☐ eating certain foods	☐ bending forward	☐ quick head / body movement
☐ riding/driving in a car	☐ time of day	☐ busy public environments
☐ loud noises	☐ bright lights	☐ riding on escalators/elevators
☐ looking up/down	☐ medication	☐ physical activity/exercise
☐ walking	☐ visual motion	☐ blowing nose, coughing, straining
☐ stress	☐ menstrual period (if applicable)	☐ other _____

Is there anything that makes your symptoms better? ☐ Yes ☐ No

If yes, please explain: _____

When you have symptoms, do you need to support yourself to stand or walk? ☐ Yes ☐ No

If yes, how do you support yourself? _____

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

# of falls in the last month _____ **week** _____

Explain: _____

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

HOW OFTEN? _____

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

WHEN YOU ARE WALKING, DO YOU: ☐ Veer left? ☐ Veer right? ☐ Remain in a straight path?

RESULTS OF IMAGING TESTS:

☐ **MRI:** Date: _____ Results: _____

☐ **CT SCAN:** Date: _____ Results: _____

☐ **MRA or DOPPLER** (for carotid and/or vertebral artery testing)**:**
Date: _____ Results: _____

RESULTS OF VESTIBULAR TESTS:

☐ **VNG / CALORICS**	Date: _____	Results: _____
☐ **ROTATIONAL CHAIR**	Date: _____	Results: _____
☐ **HEARING**	Date: _____	Results: _____
OTHER _____	Date: _____	Results: _____

CURRENT AND PRIOR ACTIVITY LEVEL:

Current activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous
List activities/hobbies: _____

Prior activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous
List activities/hobbies: _____

ACTIVITIES RESTRICTED DUE TO CONDITION: _____

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

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

☐ Other: _____

MEDICATION

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

Other medications: _____

☐ **Please check if you have provided a list of your medications to our office.**

PATIENT'S NAME: _____ **DATE:** _____
First **MI** **Last**

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 activities?	**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 **(please do not calculate)**

Sub Total	___ x4	___ x0	___ x2
Total	___	___	___ = ___

P ____ **E** ____ **F** ____

PATIENT'S NAME: _____ **DATE:** _____
First **MI** **Last**

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 (please do not calculate)

TOTAL _____%

In your words, please describe what you would like to achieve / improve by coming to Physical Therapy:

- _____
- _____
- _____