**SUBJECTIVE**

**Age:** ______  **When did your symptoms start?** ______________________________________

**Hand Dominance:** □ Right □ Left  **Date of next Doctor’s appointment:** _____________________

**Describe the current problem that brought you here:** ______________________________________
______________________________________________________________________________________

**Are your symptoms:** □ Improving □ Getting Worse □ Staying the Same

**Have you had any testing?** □ X-rays □ MRI □ EMG/Nerve Conduction Test □ CT Scan □ VNG/ENG □ Other  **Results:** ______________________________________

**Have you ever had these symptoms before?** □ Yes □ No  **Description:** ______________________

**Have you ever had treatment before for these symptoms?** □ Yes □ No  **If Yes, please describe:**

- **Medication:** Beneficial? □ Yes □ No  **Explain:** ______________________
- **Injection:** Beneficial? □ Yes □ No  **Explain:** ______________________
- **Physical Therapy:** Beneficial? □ Yes □ No  **Explain:** ______________________

**Did you have surgery?** □ Yes □ No  **Date of Surgery:** ______________________
**If yes, what procedure did you have done?** ______________________________________

**Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?** □ Yes □ No  **Explain:** ______________________________________

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**FUNCTIONAL ABILITIES AND RESTRICTIONS**

**What activities are difficult to perform due to your condition?** □ Squatting □ Sitting □ Standing

- □ Walking □ Lifting □ Dressing/Grooming □ Driving □ Stairs □ Reaching □ Work Tasks
- □ Gripping/Pinching □ Kneeling □ Position Changes □ Other: ______________________

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**What activities make your symptoms WORSE?** ______________________________________

**What activities make your symptoms BETTER?** ______________________________________

**What were you doing prior to this injury that you are unable to do currently?** ______________________
______________________________________________________________________________________

**DIZZINESS RATING:** In past six months, what percentage of the time has dizziness interfered with your activities?  **Please mark on line below.**

<table>
<thead>
<tr>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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</thead>
</table>

**What household activities are you having trouble doing or cannot do by yourself?** *(Please mark all that apply.)*

- □ Cooking □ Cleaning □ Vacuuming □ Laundry □ Grocery Shopping □ Yard Work  
- □ Driving □ Other: ______________________

**Do you use an assistive device?** □ None □ Cane □ Walker □ Wheelchair □ Other: ______________________

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### Patient Name: __________________________ Date of Birth: __________ Date of Eval: __________

#### CURRENT COMPLAINTS

If you have pain, what is your pain level?

(0 = No Pain, 10 = Extreme Pain – Circle)

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<tr>
<th>AT WORST:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tr>
<td>AT BEST:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>CURRENTLY:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

Are your symptoms:
- □ Constant  □ Come and Go  □ Ache  □ Deep  □ Superficial  □ Dull
- □ Sharp  □ Shooting  □ Burning  □ Numbness/Tingling
- □ Other: ___________________________________________________

**Day Pattern:**

Does your pain seem to be WORSE at a certain time of day?  □ Yes  □ No
- If Yes, □ Morning  □ Night  □ Other: __________________________

Does your pain progress as the day goes along?  □ Yes  □ No
- If Yes, please explain: ________________________________________

Do you have difficulty falling asleep?  □ Yes  □ No
- If Yes, please explain: ________________________________________

Do you wake due to pain?  □ Yes  □ No  □ If Yes, # of times per night: _____

**Symptom Description:**
- □ Lightheaded  □ Dizzy  □ Spinning  □ Motion Sickness

How long do your symptoms last?  □ < 1 min  □ 5-10 min  □ Continuous  □ Hours  □ Other: _____

When was the last time symptoms occurred? __________________________

Do your symptoms (check all that apply):
- □ Occur spontaneously  □ Occur with movement
- □ Occur with positional changes  □ Other: __________________________

### SAFETY PRECAUTIONS

**Sense of Balance:**

Have you had any falls in the past 12 months?  □ Yes  □ No
- If Yes, how many times? __________________________

If Yes, please describe the nature of the fall (s): __________________________

If Yes, please describe if an injury(ies) occurred: __________________________

When was the last fall(s)? __________________________

Was fall(s) because of dizziness?  □ Yes  □ No

Do you experience near falls or need to hold onto walls, furniture, etc. to maintain your balance at times?
- □ Yes  □ No  □ If Yes, describe: __________________________

How often? __________________________

When was the last time this occurred? __________________________

Do you lose your balance while walking?  □ Yes  □ No
- If Yes, check all that apply: □ Uneven surfaces □ Dark □ Outside □ With Fatigue

Do you feel like you drift to one side while walking?  □ Yes  □ No
- If Yes, to which side? □ Right □ Left □ Both

---

**THERAPIST COMMENTS:**

________________________________________________________

________________________________________________________

________________________________________________________

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### WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

<table>
<thead>
<tr>
<th>Occupation: _____________________________</th>
<th>Presently Working:</th>
<th>Yes</th>
<th>No</th>
<th>THERAPIST COMMENTS:</th>
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<tr>
<td>If Yes,  □ Full Duty □ Limited Duty: Restrictions: ___________________________</td>
<td># Days Off Work:</td>
<td></td>
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<tr>
<td>Job Duties: □ Sitting □ Computer Work □ Bending □ Heavy Lifting □ Traveling □ Standing □ Reaching □ Crawling □ Twisting □ Walking □ Pushing/Pulling □ Gripping/Pinching □ Other: ___________________________</td>
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<tr>
<td>Are you now, or have you ever been disabled (service or work)? □ Yes □ No</td>
<td>If Yes, when? __________</td>
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<td>If Yes, please explain: ___________________________</td>
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<tr>
<td>What is your current living arrangement? □ Alone □ Spouse □ Partner □ Family □ Other: ___________________________</td>
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<tr>
<td>Does your home have stairs? □ Yes □ No</td>
<td>If Yes, # of stairs:</td>
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<tr>
<td>If Yes, do your stairs have handrail? □ Yes □ No</td>
<td>If Yes, which side going up? □ Right □ Left □ Both</td>
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<tr>
<td>Hobbies/ Interests/ Exercise: ___________________________</td>
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### PREVIOUS MEDICAL HISTORY

**How would you classify your general health?** □ Good □ Fair □ Poor

*In terms of your general health, please check ALL that apply:*

- □ Allergies
- □ Rheumatoid Arthritis
- □ Metal Implants
- □ Recent Headaches
- □ Recent Vision Changes
- □ Sexual Dysfunction
- □ Osteoarthritis
- □ Heart Palpitations
- □ Chest Pain/Anemia
- □ Stroke/TIA
- □ Physical Abnormalities
- □ Hypoglycemia
- □ Night Pain
- □ Migraines
- □ Kidney Problems
- □ Catarsacts
- □ Polio
- □ Anemia
- □ Recent Fever
- □ Ringing of the Ears
- □ Recent Nausea/Vomiting
- □ Heart Attack
- □ Osteoporosis
- □ Hernia
- □ Depression
- □ Recent Fractures
- □ Heart Disease
- □ Macular Degeneration
- □ Liver/Gallbladder Problem
- □ Fibromyalgia
- □ Asthma/Breathing Difficulties
- □ Seizures/Epilepsy
- □ Recent Dizziness/Fainting
- □ Recent Change in Bowel/Bladder Habits
- □ Pain with Cough/Sneeze
- □ Recent Unexplained Fatigue
- □ Numbness/Tingling in Hip/Buttocks Area
- □ Diabetes I or II
- □ Unexplained Weight Loss/Gain
- □ Pregnancy (Currently)
- □ Recent Unexplained Fatigue
- □ Meniere’s disease

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? ____________________________________________________________

### MEDICATIONS

**Please list all of the medications [with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)] that you are currently taking (including over-the-counter, prescriptions, herbas, and vitamins/minerals):**

- □ See Attached List

### PATIENT GOALS FOR THERAPY

**What are your goals for participating in Therapy?**

- □ See Attached List

### SIGNATURES

*To the best of my knowledge I have fully informed you of the history of my problem and current status.*

**Patient’s Signature:** ___________________________ Date: __________

**Therapist’s Signature:** ___________________________ License #: __________ Date: __________

**Printed Therapist’s Name:** ___________________________