ReQuest
PHYSICAL THERAPY

Vestibular Questionnaire/Health History

To better serve you, it is important that you complete this medical history as completely and as accurately as possible.

Personal Information

Name:______________________________ Date:__________ Age:______

Mailing Address:______________________________

Date of Birth:______________ Email:______________________________

Home Phone Number:(______)______________ Cell Phone Number:(______)______________

Date of Initial Injury:______________ Date of Most Recent Increase of Symptoms:______________

Referring Physician:______________ Primary Care Physician:______________

Please check the appropriate response:

	YES	NO
Do you smoke?		
Do you exercise regularly?		
Is your current condition work accident related?		
Is your current condition auto accident related?		
Have you had physical, occupational, speech, massage, or chiropractic care for any reason this year?		

Past Medical History

Please check YES if you have ever (in your life) had, or do you presently have any of the following and provide details of all YES answers below:

____

____

____

	YES		YES		YES		YES
Allergies		Cancer/Tumor		Heart Disease		Parkinson's Disease	
Anemia		Cholesterol (High)		Hernia		Rheumatism	
Arthritis		Diabetes		Hypertension		Skin Disease	
Asthma		Dizziness/Fainting		Kidney Disease		Shortness of Breath	
Back Problems		Emphysema		Lung Disease/COPD		Spinal Injury	
Blood Disease		Epilepsy/Seizures		Multiple Sclerosis		Stroke	
Bone/Joint Problems		Fibromyalgia		Osteoporosis		Swelling	
Breathing Issues		Headaches		Pace Maker		Ulcers	
Broken Bones		Head Injury		Paralysis			

Other:______________________________

Past Surgeries

If you have had any prior surgeries please give details below:

Surgery / Procedure	Date

Medications

Are you allergic to any medications? YES/NO If YES, what? ______________________________

If you are currently taking medications please list below:

1		5	
2		6	
3		7	
4		8	

History of Present Condition

Which of the following best describes your symptoms? (check all that apply)

___ Imbalance
___ Trouble Walking
___ Staggering
___ Sense of leaning/tilt
___ Undulations (as if on a boat)
___ Vertigo (spinning events)
___ Nausea/Queasiness
___ Visual Confusion
___ Blurry Vision
___ Jumping Vision
___ Ringing in Ears
___ Hearing Loss
___ Headache
___ Pain in neck
___ Lightheadedness
___ Disorientation
___ Poor concentration, memory, or attention
___ Fatigue
___ Weakness (location:______________________________)
___ Other:____

When did you first notice these symptoms? ____

Was the onset of this episode gradual or sudden? (circle one) Gradual Sudden

Are your symptoms (check all that apply)

___ Constant ___ Provoked by head movement or activity ___ Spontaneous

Have you ever fallen? (circle one)

No Yes (once in last week) Yes (more than once this week) Other:__________________

What aggravates your symptoms?

___ Lying down
___ Going to/rising from sitting
___ Riding in or driving a car
___ Walking
___ Visual motion
___ Medication
___ Other:____

Previous Functional Level

___ Independent in all activities (work, community, home, recreation)

Self Care

___ Independent in all self-care (bathing, toileting, dressing, etc.) activities
___ Have difficulty performing self-care activities
___ Need assistance with self-care activities
___ Have difficulty performing household chores

Social

___ Need assistance with activities in community

Hobbies:____

"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge."

____ ____________________

Patient Signature Date

ReQuest
PHYSICAL THERAPY
Comprehensive care with a personal touch

PATIENT ATTENDANCE POLICY

In order to assure that all patients receive the time and attention they deserve, the following guidelines have been established:

1. If you arrive late for a scheduled appointment, you may not be able to be seen that day.
2. If you need to cancel an appointment, please notify us as soon as possible. If we are unable to take your call, please leave a message on our voicemail.
3. If you cancel with less than 24 hours notice or no show a scheduled appointment:
   - The first cancellation/no show fee will be waived.
   - On the second and any subsequent occurrence, you may be charged a $25 fee.

Please note that any cancellation/no show fees are at the discretion of the treating therapist and/or the front desk manager. If you fail to keep scheduled appointments, you may be discharged from therapy.

"I have read and understand this policy"

Patient Name (please print) ______________________________

Patient / Guardian Signature ______________________ Date __________

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPAA

"I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the family members or friends listed below:"

Name ______________________________

Name ______________________________

Name ______________________________

Name ______________________________

Patient Name (please print) ______________________________

Patient / Guardian Signature ______________________ Date __________

ReQuest
PHYSICAL THERAPY
Comprehensive care with a personal touch

INSURANCE ASSIGNMENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize ReQuest Physical Therapy to release to any third party payer (such as an insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

THERAPIST/CENTER INSURANCE ASSIGNMENT I, the below named patient, hereby authorize payment directly to ReQuest Physical Therapy and/or any therapist examining or treating me for any group and/or individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. I understand and agree that the center providing services is based on a treatment team approach to care. The treatment team consists of physical therapists, physical therapist assistants, licensed massage therapists, exercise specialists, athletic trainers and interns in training working under the direction and supervision of the treating physical therapist.

MEDICARE PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST I, the below named patient, certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration\Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the center/therapist treating me.

MY RESPONSIBILITY I, the below named patient, understand it is my responsibility to pay at time of service any deductible amount, co-payment, co-insurance or any other balance not paid for by my insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT REQUEST PHYSICAL THERAPY. This assignment will remain in effect until revoked by me in writing.

Patient Name (please print) ________________________________

Patient / Guardian Signature ______________________ Date ____________

Dizziness Handicap Inventory

Name: ______________________________ DOB: ________________ Date: ____________

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.
Answer each question as it applies to your dizziness or unsteadiness only.

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 into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are your afraid to leave your home without having someone accompany 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	Because of your problem, 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?	F			
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 the house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationship 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			
			X 4	X 0	X 2
		=			
	TOTAL				

P ______________ E ______________ F ______________

□ 100-70= severe perception of having a handicap, □ 69-40= moderate perception of handicap, □ 39-0= low perception of handicap