FYZICAL Therapy & Balance Centers

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Vestibular Rehabilitation — Initial Evaluation Dizziness and !glance Center

Date:_____

Patient: _____ Medical Record #: _____ D.O.B. _____ Age: _____

Referring physicians and physicians to whom we should send report (please give addresses):

When did this problem begin? _____

HPI:

Current Complaints: Describe the major problem or reason you are seeing us:

Specifically, do you experience spells of vertigo (a sense of spinning)? Yes No

If YES, how long do these spells last? _____

When was the last time the vertigo occurred _____

Is the vertigo: (check those that apply)

Spontaneous	Induced by motion	Induced by position changes

Do you experience a sense of being off-balance (disequilibrium)? (Ye) (N)

If yes, is/does the feeling of being off-balance: (check those that apply)

Spontaneous	Induced by motion	Induced by position changes	
Worse with fatigue	Worse outside	Worse in the dark	Worse on uneven surfaces
Occur when lying down	Occur when sitting	Occur when standing still	Occur when walking

Are your symptoms worse with?

Movement of the visual environment? Yes No	Complex visual environments? Yes No	Visual patterns? Yes No	Self-motion? Yes No
Do you have difficulty performing precise visual tasks? Yes No			

Do you or have you fallen (to the ground or floor)? Yes No

If yes, please describe _____

When did this happen? _____

How often do you fall? _____ Did the (falls) occur because of your dizziness? _____

When was your last fall? _____

Have you injured yourself? Yes No If yes, please describe _____

Do you or have you had near falls (where if you hadn't grabbed something or someone you would have fallen?) Yes No

Yes (describe) _____

How often? _____ When was the last time? _____

Do you stumble, stagger or side-step while walking? Yes No Do you drift to one side while you walk? Yes No

Do you have any pain? Yes No If yes, where ? _____ How bad is the pain currently? (0-10) _____

How bad is the pain at its worst? (0-10) _____

Social History/living environment:

PERTINENT Past Medical History: Do you have (check those that apply):

Diabetes	I Heart Disease	Hypertension	L Headaches	L Weakness /paraysis 1
Cervical Problems	Back Problems	Arthritis	Pulmonary problems	
Hearing problems	Cataracts	Macular degeneration	Other visual problems	

Other health problems:

Have you had any surgeries? Yes No

If yes, please list with approximate dates: _____

_____

Have you been in a serious accident recently? Yes No If yes, when did it occur? _____

If `yes', please describe _____

What medications do you take?: _____

Are you allergic to any medication? If yes, _____

PANAS: from Hazlett, Tusa and Waranch. Development of an Inventory for Dizziness and Related Factors. J Behavioral Med 19: 73- 85 ; 1996.

The scale below consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you generally feel this way. That is, how do you feel on the average. Use the following scale to record your answers:

1	2	3	4	5
very slightly or not at all	a little	moderately	quite a bit	extremely

There should be a response for each word.

_____interested	_____irritable	_____jittery	_____strong	_____nervous
_____enthusiastic	_____distressed	_____alert	_____ active	_____excited
_____ ashamed	_____afraid	_____upset	_____inspired	_____hostile
_____guilty	_____determined	_____proud	_____scared	_____attentive

Instructions: In the last week, what percentage of the time has dizziness interfered (slower, harder to do, could not do at all) with your activities? Mark the line below.

0% 20% 40% 60% 80% 100%

In the last week, what percentage of the time has dizziness prevented (could not do at all) your activities? Mark on the line below

0% 20% 40% 60% 80% 100%

What was your functional level of activities before this problem developed?

_____

Current functional status:

Are you independent in self-care activities: (Ye) (N)

Check which things you cannot do by yourself:

_____ Dress _____ Bathe _____ Get on and off toilet

_____ Prepare simple meal _____ Light house cleaning

Do you drive? In the daytime? Yes No In the nighttime? Yes No

If you are driving, have your driving habits changed because of your dizziness? Yes No

If yes, in what way? _____ limited night time

_____ limited high speed

_____ no high speed

_____ more cautious in general but not limited

_____ other _____

Are you working? (Ye) (N) Not applicable; occupation: _____

Instructions: Please answer the following questions about your dizziness and how it affects your life. Read each question and then circle a number on the scale under that question to indicate how that question applies to you.

1. Rate the level of your dizziness at the present moment.

0	1	2	3	4
none	slight	moderate	quite a bit	extreme

2. Since the time your dizziness began, how much has your dizziness changed your ability to work? (____check here if you have retired for reasons other than your dizziness).

0	1	2	3	4
not at all	slightly	moderately	quite a bit	very much

3. How much has your dizziness changed your ability to do household chores?

0	1	2	3	4
not at all	slightly	moderately	quite a bit	very much

4. Does your dizziness significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or parties?

0	1	2	3	4
not at all	slightly	moderately	quite a bit	very much

5. To what extent does your dizziness prevent you from driving your car?

0	1	2	3	4
not at all	slightly	moderately	quite a bit	very much

For the following, please pick the one statement that best describes how you feel (from Shepard et al 1990):

_____ Negligible symptoms

_____ Bothersome symptoms

_____ Performs usual work duties but symptoms interfere with outside activities

_____ Symptoms disrupt performance of both usual work duties and outside activities

_____ Currently on medical leave or had to change jobs because of symptoms

_____ Unable to work for over one year or established permanent disability with compensation payments

From: Jacobson GP, Newman CW. The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg.* 1990;1 16:424.

are a series of questions that pertain to your problem. You should respond " yes, sometimes, no"

	Yes	sometimes	no
1. Does looking up increase your problem?	___	___	___
2. Because of your problem, do you feel frustrated?	___	___	___
3. Because of your problem do you restrict your travel?	___	___	___
4. Does walking down the aisle of a supermarket increase your problem?	___	___	___
5. Because of your problem, do you have difficulty getting into or out of bed?	___	___	___
6. Does your problem significantly restrict your participation in social activities?	___	___	___
7. Because of your problem do you have difficult reading?	___	___	___
8. Does performing more ambitious activities increase your problem?	___	___	___
9. Because of your problem, are you afraid to leave home without having someone with?	___	___	___
10. Because of your problem, are you embarrassed in front of others?	___	___	___
11. Do quick head movements increase your problem?	___	___	___
12. Because of your problem, do you avoid heights?	___	___	___
13. Does turning over in bed increase your problem?	___	___	___
14. Because of your problem is it difficult for you to do strenuous work?	___	___	___
15. Because of your problem, do your avoid driving your car in the daytime?	___	___	___
16. Because of your problem, are you afraid people think you are intoxicated?	___	___	___
17. Because of your problem, is it difficult for you to go for a walk by yourself?	___	___	___
18. Does walking down a sidewalk increase your problem?	___	___	___
19. Because of your problem, is it difficult for you to concentrate?	___	___	___
20. Because of your problem, is it difficult for you to walk around your house in the dark?	___	___	___
21. Because of your problem, are you afraid to stay home alone?	___	___	___
22. Because of your problem, do you feel handicapped?	___	___	___
23. Because of your problem, do you avoid driving your car in the dark?	___	___	___
24. Has your problem placed stress on your relationships with members of your family or friends?	___	___	___
25. Because of your problem, are you depressed?	___	___	___

From: Hall CD, Herdman SJ. Reliability of clinical measures used to assess patients with peripheral vestibular disorders. *J neurol phys ther*. 2006;30:74.

Name _____ Emory _____ Date _____

Please ac a mark on the lin below corresponding to how dizzy you fee1 right now as you are sitting.

As bad as 1 t can be

No dizziness at ti