TRIANGLE PHYSIOTHERAPY & REHABILITATION

PATIENT REGISTRATION FORM FOR VESTIBULAR REHABILITATION

Last Name:		First Name:
Date of Birth:		Gender: ☐ M ☐ F
Apt/Suite/Unit No:	Street:	
City:	Postal Code:	
Home Tel. #:	Work Tel. #:	Cell #:
E-mail:		Occupation:
Referring Physician:		Telephone:

HOW DID YOU HEAR ABOUT US? (MARK ALL THAT APPLY)

☐ I have been here before ☐ Doctor's Referral ☐ Yellow Pages Book ☐ yp.ca
☐ Google search ☐ Friend/Family/Co-Worker (please name) ☐ Sign Board
☐ Just Walked In ☐ Flyer ☐ VennGo ☐ Other: _____

MEDICAL HISTORY

Describe the major problem or reason you are seeing us. _____

When did the problem begin? _____

Specifically, do you experience spells of vertigo (a sense of spinning)? Y ☐ N ☐
If yes, how long do these spells last? _____
When was the last time the vertigo occurred? _____

Is the vertigo:
Spontaneous ☐ Induced by motion ☐ Induced by position changes ☐

Do you experience a sense of being off-balance (disequilibrium)? Y ☐ N ☐
If yes, is the feeling of being off-balance:
☐ Constant ☐ Spontaneous ☐ Induced by motion ☐ Induced by position changes
☐ Worse with fatigue ☐ Worse outside ☐ Worse in the dark ☐ Worse on uneven surfaces

Does the feeling of being off-balance occur when:
☐ Lying down ☐ Sitting ☐ Standing ☐ Walking

Do you or have you fallen (to the ground) ☐ Y ☐ N
If yes, please describe. _____
How often do you fall? _____
Have you injured yourself? _____

Do you stumble, stagger or side-step while walking? ☐ Y ☐ N
Do you drift to one side while you walk? ☐ Y ☐ N
If yes, to which side do you drift? ☐ Right ☐ Left

☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Headaches ☐ Arthritis
☐ Neck Problems ☐ Back problems ☐ Pulmonary Problems
☐ Hearing problems ☐ Visual problems

Have you been in an accident? Y ☐ N ☐ If yes, when did it occur? _____
Please describe the accident._____

What medications are you taking? _____

Social History

Do you live alone? ☐ Y ☐N If no, who lives with you? _____
Do you have stairs in your home? ☐ Y ☐ N If yes, how many? _____
Do you have trouble sleeping? ☐ Y ☐ N

The scale below consists of a number of words that describe different feelings and emotions. Read each item and then indicate how you feel on the average using the numbers 1 2 3 4 5. Mark the number in the space next to the word.

1 Slightly/not at all 2 a little 3 moderately 4 quite a bit 5 extremely

_____ Interested	_____ irritable	_____ jittery	_____ strong	_____nervous
_____ Enthusiastic	_____ distressed	_____ alert	_____ active	_____ excited
_____ Ashamed	_____ afraid	_____ upset	_____ inspired	_____ hostile
_____ Guilty	_____ determined	_____ proud	_____ scared	_____ attentive

Functional Status

Are you independent in self-care activities? ☐ Y ☐ N
Can you drive In the day time? ☐ Y ☐ N In the night time? ☐ Y ☐ N
Are you working? ☐ Y ☐ N ☐ Not applicable
Are you on medical disability? ☐ Y ☐ N

Are you able to?
☐ Watch TV comfortably ☐ Read ☐ Go shopping
☐ Work on a computer ☐ Be in a noisy place

Initial Visit

For the following, please pick the one statement that best describes how you feel.

_____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

_____ _____
Signature **Date**