NeuroBalance Physical Therapy Medical History Form

Date:______________

Name:____ Age:_______

Referring Doctor:____

Primary Care Doctor:____

What are your symptoms?____

When and how did it begin?____

Do you have any additional injuries other than the one you are here for?

Yes/ No *If yes, what:*____

List all prescription, over-the-counter medications, and supplements you are currently taking.

____

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Do you have symptoms of dizziness or unsteadiness? **Yes/No**

If yes, please complete the following:

Which of these describe your symptoms of dizziness? **Circle below**

Lighteaded	**Rocking**	**Unsteady**	**Floating**
Nauseated	**Disoriented**	**Spinning**	**Blurred Vision**

How often do you experience symptoms of dizziness?________________________

How long do your symptoms of dizziness last?______________________________

Do you experience a sensation of movement at rest?_________________________

What has been the progression of your symptoms?

Has gotten better_____

Has gotten worse_____

Has stayed the same____

Have you had any falls? (A sudden, unintentional change in position causing you to land at a lower level, on an object, the floor, or the ground) **Yes/No**

If yes, how many in the last year:____

Have any of the falls resulted in injury?_______ If yes, how many?______________

Do you have pain? **Yes/No**

If yes, where?____

If yes, rate the intensity from 0-10____

Have you had any x-rays, CT scans, MRI, or VNG Vestibular testing done? **Yes/No**

If yes, what? ____

Results (If known)? ____

Please list any operations that you have had and the date(s):

Operation Date

____

____

ARE YOU UNDER ANY ACTIVITY OR LIFTING RESTRICTIONS FROM YOUR DOCTOR?

YES/NO IF YES, WHAT?____

FITNESS:

Do you participate in any exercise? ***Yes/ No***

*If yes, list the type of exercise, days/week*___________________________________

PAST MEDICAL HISTORY

Have you experienced any of the following problems:	No	Yes	In treatment currently (Y/N)? If yes, please list the provider to allow collaboration as needed, with your signed permission only.
Bowel and Bladder Changes			
Numbness or Tingling			
Migraine Headaches			
Other Headaches			
Joint Stiffness/Pain			
Rashes			
Angina or Chest Pain			
Shortness of Breath			
Unexplained Fatigue			
Depression			

Loss of Appetite			
Neck Pain			
Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Whiplash			
Arthritis/Gout			
Concussion/Head injury			
Epilepsy			
Multiple Sclerosis			
Thyroid Problems			
Fibromyalgia			
Tuberculosis			
Polio			
Stroke			
Allergies			
Meniere’s disease			
Parkinson’s disease			
Neuropathy			
Other:			

Occupation:____

Are you currently working?____

Are you on disability or leave due to your condition?____________________

For Staff Only:
Review of this document has been completed. No contraindications to proceeding with PT evaluation or treatment have been identified. ____