HealthEast Care System

HealthEast Optimum Rehabilitation

- ☐ Maplewood Phone: 651/ 232-7820 Fax: 651/ 232-7832
- ☐ Oakdale Phone: 651/ 232-5075 Fax: 651/ 232-5085
- ☐ University Park/Midway Phone: 651/ 232-5412 Fax: 651/ 232-4971
- ☐ Woodwinds/Woodbury Phone:651/ 232-6767 Fax: 651/ 232-6766

MEDICAL HISTORY/SUBJECTIVE INFORMATION - VESTIBULAR

Name you Prefer: ______________________________ Next M.D. Visit Date: ____________________

Allergies/Reactions: ____ ☐ **None**

Sensitivities: ☐ **Elastic** ☐ **Latex** ☐ **Tape** ☐ **None**

Medications Currently Taking: ☐ None Purpose	**Medication:** Purpose

Have you ever been diagnosed with any of the following? ☐ **None**

☐ Rheumatoid Arthritis	☐ Diabetes	☐ Cancer (Specify ________________)
☐ Osteoarthritis	☐ Heart Disease/Condition	☐ Fibromyalgia
☐ High Blood Pressure	☐ Respiratory Problems	☐ Metal Implant
☐ Low Blood Pressure	☐ Osteoporosis	☐ Other ______________________
☐ Stroke	☐ Multiple Sclerosis	

Surgeries or other Procedures: **Date:**	**Date:**

How do you best learn? Please circle: Listening Pictures Watching Reading

How would you rate your stress level? ☐ Low ☐ Medium ☐ High

In the past year, have you been a victim of abuse (physical, emotional, financial or sexual)? ☐ **Yes** ☐ **No**

Have you ever had an ear, head or neck injury? ☐ Yes ☐ No
If yes, when? _____________ How? ______________________________

Have you ever had any **ear**, **head** or **neck** surgeries? ☐ Yes ☐ No
If yes, when and what? ______________________________

Have you had any imaging of the **head**? ☐ Yes ☐ No
If yes, CT MRI When? __________________ Results? ____________________

Have you had an ENG? ☐ Yes ☐ No If yes, when? __________________ Results? ____________________

Have you had a recent hearing test? ☐ Yes ☐ No If yes, when? ______________ Results? _______________

Have you recently had a flu or viral infection? ☐ Yes ☐ No If yes, when and describe? ____________________

Have you recently received IV antibiotics or chemotherapy? ☐ Yes ☐ No

Do you have a family history of dizziness or vertigo? ☐ Yes ☐ No

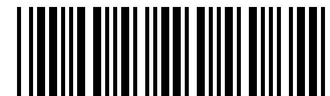
Do you take any medication for your dizziness or vertigo? ☐ Yes ☐ No

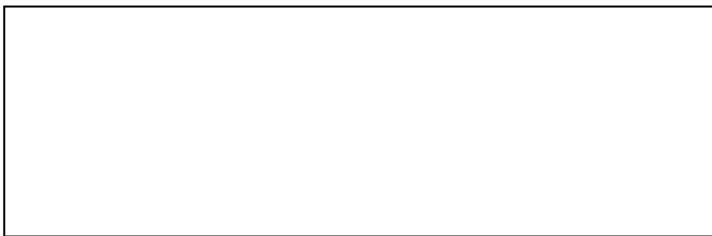
Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times?______ Date of most recent fall? ________

Were you injured? ☐ Yes ☐ No If yes, list injuries: ______________________________

Describe the circumstances regarding your fall(s) (e.g. tripped, slipped, dizzy, weak, just fell, etc.)

____





Do you use an assistive device for ambulation? ☐ Yes ☐ No If yes, what kind? ___________________________

PREVIOUS MEDICAL CARE (for this condition):

Physical Therapy: What Rx ___________________ When ____________ Helpful? _____________ ☐ Yes ☐ No Other ______________

Occupational Therapy: What Rx ___________________ When ____________ Helpful? __________ ☐ Yes ☐ No Other _____________

IF YOU ARE EMPLOYED, COMPLETE THE FOLLOWING SECITON ☐ **NOT EMPLOYED** ☐ **RETIRED**

1. What is your current job title/occupation: ____
2. What are your job activities and work positions? ____
3. Are you currently working? ☐ Yes ☐ No If yes, number of hours per week ________ ☐ Full duty ☐ Restricted duty

Symptoms:

Do you experience spells of dizziness, vertigo or lightheadedness? ☐Yes ☐No (if no, skip the remainder of the section)

When (date) did this first occur? _________________ What were you doing? ______________________________

What time of day do you feel best? AM PM All day No pattern Worst? AM PM All day No pattern

Description of symptoms:

Onset:	sudden	gradual			
Type:	room spinning	self spinning	lightheaded	heaviness in head	occular dizziness
Frequency:	number of attacks	______per day	______ per week	______ per month	
Duration:	seconds	minutes	hours	Constant	
Worsened by:	fatigue	movement	exertion	hunger	alcohol
	menstration	emotional upset	other _______________________________		

Do you know of anything that provides relief of your symptoms? ____________________________________

Associated symptoms: (check as many as apply)

☐ nausea	☐ vomiting	☐ headache	☐ visual problems	☐ difficulty reading
☐ weakness	☐ clumsiness	☐ faintness	☐ ringing in ears	☐ ear pressure/fullness/discharge
☐ hearing loss	☐ loss/change of consciousness		☐ slurred speech	☐ difficulty swallowing
☐ Tingling/numbness (finger, toes, mouth)				

Do your symptoms increase when?:

Straining (e.g. blowing your nose, coughing, sneeze, bowel movement)? ☐ Yes ☐ No

Experiencing pressure changes (e.g. in an airplane, mountains or under water)? ☐ Yes ☐ No

Hearing sudden loud noises?	☐ Yes	☐ No	Chewing gum or food?	☐ Yes	☐ No
Turning your head to your left / right?	☐ Yes	☐ No	Looking up / down?	☐ Yes	☐ No
Rolling over in bed?	☐ Yes	☐ No	Bending over?	☐ Yes	☐ No
Standing up from sitting or lying?	☐ Yes	☐ No	Squatting or kneeling?	☐ Yes	☐ No
Walking in a crowd of people?	☐ Yes	☐ No	Walking in the dark?	☐ Yes	☐ No
Walking on uneven surfaces?	☐ Yes	☐ No	Stepping off curbs?	☐ Yes	☐ No

GOALS: What do you expect to accomplish with PT/OT? ____________________________________

PATIENT SIGNATURE: ____

Your therapist will complete this section:

CONSENT: I agree with the treatment plan of care. ☐ **Yes** ☐ **No** **Patient Initials** ____________

ABUSE: ☐ Yes ☐ No Refer to Social Services ____

Therapist's Printed Signature: ____________________________________ Date: ____________________