Patient Information

(incomplete forms will delay your appointment)

Name: _____ Middle: _____ Last: _____ ☐ Male ☐ Female

Address:_____ Apt/Unit: _____

City:_____ State:_____ Zip:_____

Home Phone:_____Work: _____ Cell: _____ Email: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____

Home Phone #: _____ Cell #: _____ E-Mail: _____

Emergency Contact: _____ Phone #:_____ Relationship:_____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? ☐ Y ☐ N

Name: _____ Phone #: _____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer:_____ Address:_____

Medical Doctor Information:

Referring Physician:_____ Phone #: _____

Address:_____City:_____ State:_____ Zip:_____

Family Physician:_____ Phone #:_____

Please state briefly the nature of your problem: _____

Please list operations you have had: _____

Please name any medications you are allergic to or have been advised not to take:

_____

Please Check Any of the Following You Have Had or Currently Have:

☐ Heart Disease	☐ Tuberculosis	☐ Artificial Joints	☐ Diabetes	☐ Cancer	☐ Ringing in Ears
☐ Pacemaker	☐ Breathing Problems	☐ Back Problems	☐ Stroke	☐ Depression	☐ Infection / Wounds
☐ Circulation Problems	☐ Emphysema / COPD	☐ Neck Problems	☐ Parkinson's Disease	☐ Nausea	☐ Blood Disorders
☐ High Blood Pressure	☐ Asthma	☐ Arthritis	☐ Epilepsy / Seizures	☐ Ulcer Disease	☐ Glaucoma

Other:_____

Acknowledgement of Payment (Check All That Apply)

☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover

Primary Insurance: _____ ID#: _____ Group #: _____

Primary Card Holder Name: _____Primary Card Holder Date of Birth: _____/_____/_____

Secondary Insurance Name: _____ ID#: _____ Group #: _____

INITIAL HERE

☐ **I understand that I am ultimately responsible for the balance on my account for any professional services rendered.** I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Authorization for Treatment

The patient /legal guardian authorized _____ to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature: _____ Date: _____

PATIENT INTAKE

Patient Name: _____ **Date of Birth:** ___/___/_____ **Sex:** Male / Female

Provider Name: _____ **Appt Date:** ___/___/_____

CURRENT SYMPTOMS

Which of the following **best describes your symptoms**?

- ○ imbalance
- ○ falling more often
- ○ nausea
- ○ world spinning around you
- ○ you feel as if you are spinning; the world is not spinning
- ○ lightheadedness
- ○ other: _____

How long do your symptoms last **without stopping**?

○ seconds ○ minutes ○ hours ○ days ○ constant

Circle One: How many times per **day / week / month / year** do you have an episode? _____

Did any of the following occur **immediately before your symptom** onset? *(check all that apply)*

- ○ head trauma
- ○ motor vehicle accident
- ○ upper respiratory infection
- ○ change in medication
- ○ a fall
- ○ a virus or infection, e.g., shingles, cold sores, covid-19
- ○ surgery
- ○ stressful event or high-stress
- ○ other: _____

Circle One: Have your symptoms **improved / changed / stayed the same** since they began?

If Improved or Changed: How so? _____

Does anything make your symptoms better? _____

BALANCE & FALL SYMPTOMS

(Circle **Y** *for Yes, Circle* **N** *for No)*

Y N Have you fallen in the past year?

*If **yes**:* How many times? _____
*If **no**:* Have you experienced "near falls" but you caught yourself? **Y N**

Y N Are you afraid of falling?

Y N Are you veering/leaning while walking? *If **yes**:* Which direction? **right / left / both**

Y N Do you have neuropathy, numbness, or tingling in your feet or legs?

Y **N** Has your exercise decreased? *If **yes**:* Approximately when? _____

Y **N** Orthopedic injuries/issues? *If **yes**:* Please explain: _____

DIZZINESS SYMPTOMS

Y **N** Do you have a history of Migraines? *If **yes**:* When was your most recent Migraine? _____

Do any of the following trigger your symptoms? *(check all that apply)*

- ○ Increased stress
- ○ Skipping a meal
- ○ Not drinking enough water
- ○ Changes in weather
- ○ Certain foods: _____

Do any of the following **accompany** or occur **immediately prior** to an episode of your symptoms? *(check all that apply)*

- ○ Headaches
- ○ Neck Pain
- ○ Nausea/Vomiting
- ○ Shimmers, Sparkles, or flashing lights in your vision
- ○ Hearing Changes **right ear** / **left ear** / **both ears**
- ○ Fullness in your ear(s): **right ear** / **left ear** / **both ears**
- ○ Ringing in your ear(s): **right ear** / **left ear** / **both ears**
- ○ Sensitivity to *(circle **all** that apply)* **light** / **sound** / **smell** / **patterns** / **screens** / **motion**

Y **N** My dizziness is intense but only lasts for seconds or minutes

Y **N** I get dizzy when I turn over in bed

Y **N** I get short-lasting, spinning dizziness that happens when I bend down to pick something up

Y **N** I get short-lasting, spinning dizziness that happens when I go from sitting to lying down

Y **N** I can trigger my dizzy spells by placing my head in certain positions

Y **N** I have had a single severe spell of spinning dizziness that lasted for hours to a day

Y **N** After my big episode of dizziness, I could not walk for days without falling over

Y **N** I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu

Y **N** I had hearing loss in one ear at the same time I had the long episode of spinning dizziness

Y **N** I have spells where I get dizzy, and it is difficult for me to breathe

Y **N** I feel dizzy all of the time

Y **N** I am anxious most of the time

Y **N** I am bothered by patterns, screens, e.g., supermarkets

Y **N** My symptoms increase when I go from laying to sitting or sitting to standing

Y **N** When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

Y N When I cough or sneeze, I get dizzy

Y N I get dizzy when I strain to lift something heavy

Y N When I speak, my voice sounds abnormally loud to me

Y N My dizziness is provoked with head movements (up/down and/or right/left)

Y N My head is heavy like a bowling ball

Y N I have a headache that is in or starts in the back of my head

MEDICAL HISTORY

- ○ anxiety/stress
- ○ depression
- ○ motion sickness
- ○ cardiac problems
- ○ respiratory problems
- ○ thyroid dysfunction
- ○ diabetes
- ○ high blood sugar
- ○ low blood sugar
- ○ high blood pressure
- ○ low blood pressure
- ○ Meniere's disease
  date of diagnosis
  _____
- ○ stroke / TIA
- ○ eye/vision concerns

HEARING HEALTH HISTORY

Y N Do you have hearing loss?

*If **yes**:* Which ear? **right ear**, **left ear**, **both ears** *(circle one)* *If **yes**:* Was it sudden? **Y N**

Y N Do you wear hearing aids?

Y N I am experiencing ear **pain** / **ringing** / **drainage** / **fullness** (*circle all that apply)*

*If **yes**:* Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

Y N I have had ear surgery? **right ear / left ear / both ears** *(circle all that apply)*

*If **yes**:* **acoustic neuroma / mastoid / cochlear implant / other:** _____

IF APPLICABLE: FEMALE HORMONAL HISTORY

Circle One: Are you **pre / peri / post** menopausal?

Y N Have you had a hysterectomy? *If **yes**:* When? _____

Y N Have you had any changes to your contraceptives? *If **yes**:* When? _____

Y N Do you have known hormonal imbalance? *If **yes**:* Are you being treated for this issue? **Y N**

☐ litigation/workers comp?

One Sheet

Patient Name: _____ Date of Birth: ____ /____ / ____ Examiner: _____

Provider Name: _____ Appointment Date: ____ /____ / ____ Assistive Device: Yes / No

Physician Follow Up: ____ /____ / ____ Sex: Male / Female Weight/Height: _____

If patient weight is >300 lbs. or height is >6'3"
Do not perform: Hallpike, Rotary

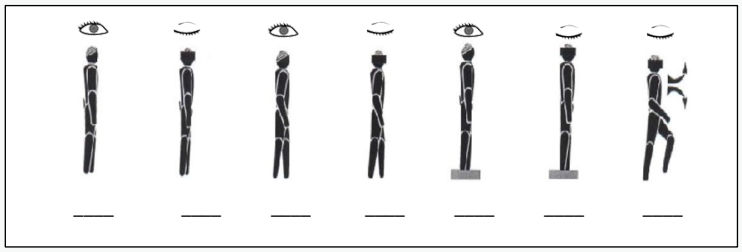
☐ interpreter used? _____

Check if Completed

☐ **Otoscopy** Unremarkable / Remarkable Notes _____

☐ **GANS SOP Test**

N = Normal
S = Sway
F = Fall
R = Right
L = Left



___ ___ ___ ___ ___ ___ ___

☐ **VNG Calibration** (Cover off): Patient-specific / Default

☐ **Random Saccades**

☐ **Smooth Pursuit**

☐ **Optokinetic**

☐ **Gaze** (cover on)

☐ **Head-Shake** - Dizziness Reported? - Yes / No - Notes: _____

☐ **Rotary Chair**

☐ **VAST** (cover off) ☐ negative ☐ positive, which head direction? ☐ L ☐ R ☐ Both

☐ dizziness ☐ double vision ☐ difficulty speaking ☐ difficulty swallowing ☐ drop attack ☐ nausea ☐ numbness ☐ eye movement

☐ **Hallpike Right** (fixation on) increased dizziness? Yes / No Dizzy sitting up? Yes / No Eye movement? Yes / No

☐ **Hallpike Left** (fixation on) increased dizziness? Yes / No Dizzy sitting up? Yes / No Eye movement? Yes / No

☐ **Supine** (Cover On) ☐ dizziness starts then stops ☐ dizziness does not stop (perform at 30°)

☐ **Head Right** ☐ dizziness starts then stops ☐ dizziness does not stop (perform at 30°)

☐ **Head Left** ☐ dizziness starts then stops ☐ dizziness does not stop (perform at 30°)

☐ **Body Right** ☐ dizziness starts then stops ☐ dizziness does not stop (perform at 30°)

☐ **Body Left** ☐ dizziness starts then stops ☐ dizziness does not stop (perform at 30°)

☐ **Calorics** (perform at 30°)

☐ **Electrode Impedance** Excellent / Fair / Poor

☐ **ABR** 95 dB 500 sweeps (perform at 30°)

☐ **EcochG** 95 dB 400 sweeps AP (1.5ms) (perform at 30°)

☐ **cVEMP** 100 dB 60 sweeps P (~13ms), N (~23ms) (perform at 15°)

☐ **oVEMP** 100 dB 100 sweeps N (~10ms), P (~16ms) (perform seated)

Other notes:

Were any tests deferred? If so, Why?

☐ GANS SOP _____
☐ VNG _____
☐ Rotary Chair _____
☐ Hallpike _____
☐ Positioning _____
☐ Calorics _____
☐ ABR _____
☐ EcochG _____
☐ cVEMP _____
☐ oVEMP _____
☐ Return for test completion
____ /____ / ____

When did symptoms first begin?

Date _____

When was your most recent episode?

Date _____

How do you describe your dizziness?

☐ see spinning constant / attacks
☐ feel spinning constant / attacks
☐ lightheaded constant / attacks
☐ imbalance/falls constant / attacks

How long do attacks last?

☐ seconds ☐ minutes
☐ hours ☐ days

Do any of these provoke symptoms?

☐ rolling over in bed
☐ bending forward
☐ tilting head back / looking up
☐ moving from sitting to lying down

Recent Head Imaging? CT / MRI

Did you take any medication for dizziness today? Yes / No

Are you currently in physical therapy? Yes / No

If Yes, for what? _____

Did your current symptoms begin after a head trauma, motor vehicle accident, or whiplash injury? Yes / No

Are you currently in litigation? Yes / No
(worker's comp, car accident, etc.)
If Yes, when did the accident occur?

Date _____

Do you currently have:

☐ sudden hearing changes L R B
☐ hearing aids L R B
☐ fullness in ears L R B
☐ ear pain L R B
☐ ear drainage L R B
☐ ringing in ears L R B

Center of Specialty Care
The American Institute of Balance®