Vestibular Questionnaire

Mendelson Kornblum P.T.

Shelby sattelite

Date:

Age:

Occupation: Retired

Date of injury or date when your pain/condition started:

What Happened?

Date surgery (if indicated):

List any other surgeries you had and the approximate year:

Please list you current medications:

Are you currently taking medications for dizziness?

Yes | No

What?

Please list prior hospitalizations:

Does your past medical history include any of the following?

			Physical Therapist Comments
Closed Head Injury?	Yes	No	
History of a stroke/TIA?	Yes	No	
History of spinal surgery?	Yes	No	
History of cancer?	Yes	No	
Pinched nerve/ neck pain?	Yes	No	
Ringing in the ears?	Yes	No	
Heart disease?	Yes	No	
Lung disease?	Yes	No	
Arthritis?	Yes	No	
Diabetes? ☐ Insulin ☐ Meds ☐ Diet	Yes	No	
Circulatory disease?	Yes	No	
High/ Low blood pressure?	Yes	No	
Psychiatric illness?	Yes	No	
Memory loss?	Yes	No	
Have you had tuberculosis test that was positive?	Yes	No	
Osteoporosis?	Yes	No	
History of falling? If yes how often? Where?	Yes	No	

Do you have an Advanced Directive (Durable power of Attorney for Health Care)?	Yes	No	
If no, would you like information about Advanced Directive?	Yes	No	
Your safety is our number one priority. Are there any questions or concerns you have at this time regarding your safety?	Yes	No	

Information in regards to your vestibular symptoms:

0= Feel normal, no symptoms   5= Worst symptoms ever, consider going to the ER

1. Circle your current symptoms:	1	2	3	4	5
2. Circle your symptoms at rest:	1	2	3	4	5
3. Circle your symptoms with quick movement:	1	2	3	4	5
4. Circle your symptoms with walking:	1	2	3	4	5
5. Circle your symptoms with riding in a car:	1	2	3	4	5

To be completed by PTT: Total Score_____/5=______

How would you describe your vestibular symptoms?

Check all that apply?

- ☐ Vertigo (room is spinning or you are spinning)
- ☐ Dizziness
- ☐ Light headed
- ☐ "Woozy" feeling
- ☐ Nauseous
- ☐ Unsteady
- ☐ Tilting
- ☐ Tipping
- ☐ Rocking
- ☐ Swaying
- ☐ Pressure in ears/ head
- ☐ Headaches
- ☐ Blurred vision or spots

Please circle the appropriate numbers:

Do you have any pain?   Yes   No

Where?____________________________

"0" means: you are pain free.
"10" means: your pain is so bad it would require an immediate visit to the ER.

Please circle the highest amount of pain this week? 0 1 2 3 4 5 6 7 8 9 10 na

Please circle the lowest amount of pain this week? 0 1 2 3 4 5 6 7 8 9 10 na

Information in regards to special testing

Did you undergo any of the following tests?

1. M.R.I.	1= Yes	2= No	3= Don't Know
2. Cat Scan	1= Yes	2= No	3= Don't Know
3. ENG	1= Yes	2= No	3= Don't Know
4. X-ray	1= Yes	2= No	3= Don't Know
5. EEG	1= Yes	2= No	3= Don't Know

Patient Signature:_________________________________   **Date:**________________

Reviewed by Therapist:______________________________   Date:________________

Menelson Kornblum Physical Therapy
29703 Hoover, Suite A
Warren, MI 48093
(586) 582-0340

DIZZINESS HANDICAP INVENTORY (DHI)

Instructions: The purpose of this scale is to indentify difficulties that you may be experiencing because of your dizziness. Please circle "ALWAYS", "SOMETIMES", OR "NO" to each question. Answer each question as it pertains to your dizziness or balance problem only.

P1. Does looking up increase your problem?	ALWAYS	SOMETIMES	NO
E2. Because of your problem do you feel frustrated?	ALWAYS	SOMETIMES	NO
F3. Because of your problem, do you restrict your travel for business or recreation?	ALWAYS	SOMETIMES	NO
P4. Does walking down the aisle of a supermarket increase your problem?	ALWAYS	SOMETIMES	NO
P5. Because of your problem do you have difficulty getting into or out of bed?	ALWAYS	SOMETIMES	NO
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	ALWAYS	SOMETIMES	NO
F7. Because of your problem do you have difficulty reading?	ALWAYS	SOMETIMES	NO
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	ALWAYS	SOMETIMES	NO
E9. Because of your problem are you afraid to leave home without having someone accompany you?	ALWAYS	SOMETIMES	NO
E10. Because of your problem have you been embarrassed in front of others?	ALWAYS	SOMETIMES	NO
P11. Do quick movements of your head increase your problem?	ALWAYS	SOMETIMES	NO
F12. Because of your problem do you avoid heights?	ALWAYS	SOMETIMES	NO
P13. Does turning over in bed increase your problem?	ALWAYS	SOMETIMES	NO
F14. Because of your problem is it difficult for you to do strenuous housework or yard work?	ALWAYS	SOMETIMES	NO
E15. Because of your problem are you afraid people may think you are intoxicated?	ALWAYS	SOMETIMES	NO

Continued on other side……..

F16. Because of your problem is it difficult for you to go for a walk by yourself?	ALWAYS	SOMETIMES	NO
P17. Does walking down a sidewalk increase your problem?	ALWAYS	SOMETIMES	NO
E18. Because of your problem is it difficult for you to concentrate?	ALWAYS	SOMETIMES	NO
F19. Because of your problem is it difficult for you to walk around the house in the dark?	ALWAYS	SOMETIMES	NO
E20. Because of your problem are you afraid to stay home alone?	ALWAYS	SOMETIMES	NO
E21. Because of your problem do you feel handicapped?	ALWAYS	SOMETIMES	NO
E22. Has your problem placed stress on your relationships with members of your family or friends?	ALWAYS	SOMETIMES	NO
E23. Because of your problem are you depressed?	ALWAYS	SOMETIMES	NO
F24. Does your problem interfere with your job or household responsibilities?	ALWAYS	SOMETIMES	NO
P25. Does bending over increase your problem?	ALWAYS	SOMETIMES	NO

F score: _______ E score: _______ P score: _______ TOTAL: ____________

EET

Name: ____

Birth date: ____

Home Address: ____

Phone Number:

Home: ____

Work: ____

Cell: ____

Emergency Contact:

Name: ____

Relationship: ____

Phone Number: ____

PHYSICAL THERAPY APPOINTMENT ATTENDANCE POLICY

Consistent attendance to physical therapy is an important component of your rehabilitation process. However, if you should need to cancel or reschedule an appointment, please call us at 586-439-6243.

- I have read the above information and am aware that if I miss three consecutive appointments without prior notification, I can be removed from the schedule, with all future appointments cancelled. __________Please Initial
- Please give us at least 48 hours notice before cancelling an appointment. __________Please Initial
- Please be aware that if you show up 10 minutes late for an appointment can lead to the cancellation of that appointment. _________Please Initial
- Please be aware that it is your responsibility to verify your insurance coverage including deductable, co-payments and total annual benefits. _______Please Initial

PATIENT SIGNATURE: ____**Date:**__________

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orthopedic & spine surgeons

General Consent to Outpatient Treatment

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS
Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES
I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION
I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
The Mendelson/Kornblum Notice of Privacy Practices provides information about how protected health information about me (the patient) - including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) - may be used and disclosed. I have been offered an opportunity to review the Notice before signing the consent. I understand that the terms of the Notice may change.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Mendelson/Kornblum General Consent to Outpatient Treatment and Notice of Patient Rights and Responsibilities.

Name of Patient (print)____

Signature of Patient____

Date______________________________ Time___________________

Signature of Spouse____

Date______________________________ Time___________________

Signature of Witness____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_______________________________

Date______________________________ Time___________________

Relationship____

Address____

Phone______________________________________

Signature of Witness____

Dear Patient:

Hello and Welcome to Mendelson Kornblum Physical Therapy. The entire staff would like to *Thank You for choosing Us to be Your Therapy Team.* We assure you that we are dedicated to helping you achieve your goals.

To receive the best therapy experience and optimum results, please **Read** the following **Attendance Policies** and **Recommendations**.

Attendance Policies:

- Please arrive 15 minutes prior to your Initial Evaluation and Re-Evaluations in order to fill out proper documentations. Please have photo ID, insurance card and list of current medications.
- If you are unable to keep your scheduled appointment, please call us 24 hours prior to the scheduled time so that arrangements can be made to reschedule your appointment. Our number is **586-439-6243.**
- *PLEASE NOTE* : 3 No Shows in a row can result in a discharge from therapy. No Shows are considered scheduled appointments that are not kept without prior notification.
- Please arrive on time for your scheduled appointments. If you are going to be late for your scheduled appointment please call. We will do our best to accommodate you, but please keep in mind it may be with a different therapist.

Clothing Recommendations:

- Please wear loose-fitting, comfortable clothing that are comfortable for exercise and that will allow us to access to the area of treatment.
- Please wear appropriate shoes for physical activity.

Your treatment may include some, or all of the following:

- Therapeutic exercise/activities: Performed for strengthening and/or improving mobility or gait
- Manual Therapy: Including joint mobilization techniques, soft tissue massage and myofascial release.
- Modalities: Which include but not limited to hot packs, cold packs, electric stimulation and ultrasound

We would again like to Thank You, and look forward to working with you to achieve your goals.

Sincerely,

The Staff of Mendelson Kornblum Physical Therapy