HPI VESTIBULAR

History of Present Illness

Why are you here today? (Select one)

- ○ an injury at work
- ○ an injury during a MVA
- ○ a fall
- ○ gradual onset of symptoms
- ○ an injury during sports
- ○ a surgery
- ○ sudden onset of symptoms

Additional Comments:

On what date did this occur?

Vestibular Symptoms

Please check all symptoms that apply. Please rate the severity of each on a scale of 0 to 10 with 0 being no symptoms and 10 being so bad you'd have to go to the emergency room. Please rate the levels of your current and worst symptoms over the last 7 days.

Vertigo	**Yes** **No**	Current:	Worst:	
Lightheadedness	**Yes** **No**	Current:	Worst:	
Headache	**Yes** **No**	Current:	Worst:	
Eye Strain	**Yes** **No**	Current:	Worst:	
Nausea/Vomitting	**Yes** **No**	Current:	Worst:	
Other		Current:	Worst:	

What makes your symptoms better?

- ☐ rest
- ☐ sunglasses
- ☐ dim lighting
- ☐ quiet environment
- ☐ nothing
- ☐ focusing gaze
- ☐ holding head still
- ☐ movement
- ☐ medication
- ☐ ice
- ☐ heat
- ☐ stretching
- ☐ closing eyes

What makes your symptoms worse?

- ☐ looking up or down
- ☐ staying still
- ☐ bright lights
- ☐ lying flat
- ☐ riding in a motor vehicle
- ☐ concentrating
- ☐ bending over
- ☐ closing eyes
- ☐ other
- ☐ sitting up after lying down
- ☐ turning head side to side
- ☐ moving around
- ☐ loud noises
- ☐ rolling in bed
- ☐ exercise
- ☐ busy environment
- ☐ reading

How long do your symptoms generally last when they occur? (Select one)

- ○ less than one minute
- ○ 10-60 minutes
- ○ greater than 3 hours
- ○ one to 10 minutes
- ○ 1-3 hours
- ○ symptoms are constant

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Are you here for a head injury or concussion? Yes No

If yes, do you have any of the following? (Select all that apply)
- ☐ difficulty concentrating
- ☐ difficulty reading
- ☐ difficulty speaking
- ☐ memory problems
- ☐ word-finding problems

Do you have history of a previous head injury? Yes No

Do you have pain other than headache or eye strain? Yes No

Which side? (Select all that apply)
- ☐ left
- ☐ right

Where is this pain located? (Select all that apply)
- ☐ neck
- ☐ upper back
- ☐ shoulder
- ☐ arm
- ☐ hand
- ☐ mid back
- ☐ hip
- ☐ buttock
- ☐ leg
- ☐ ankle
- ☐ foot
- ☐ knee
- ☐ lower back
- ☐ face

What makes this pain worse? (Select all that apply)
- ☐ running
- ☐ stair climbing
- ☐ kneeling
- ☐ jumping
- ☐ twisting
- ☐ pivoting
- ☐ squatting
- ☐ prolonged sitting
- ☐ standing
- ☐ bending
- ☐ sitting
- ☐ driving
- ☐ walking
- ☐ overhead reaching
- ☐ cough/sneeze/holding breath
- ☐ sleeping

What makes this pain better? (Select all that apply)
- ☐ nothing
- ☐ rest
- ☐ pain medication
- ☐ ice
- ☐ heat
- ☐ bracing
- ☐ cane/walker
- ☐ immoblization
- ☐ elevation
- ☐ cortisone injections
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ overhead reaching

How would you describe this pain? (Select all that apply)
- ☐ dull
- ☐ sharp
- ☐ aching
- ☐ throbbing
- ☐ shooting
- ☐ constant
- ☐ intermittent

Do you have other symptoms? Yes No

What are the symptoms? (Select all that apply)
- ☐ ringing in ears
- ☐ hearing loss
- ☐ imbalance
- ☐ vision problems
- ☐ walking difficulty
- ☐ swelling
- ☐ instability
- ☐ radiation
- ☐ catching
- ☐ buckling
- ☐ locking
- ☐ grinding
- ☐ stiffness
- ☐ popping
- ☐ night pain
- ☐ bruising
- ☐ discoloration
- ☐ other

What hand is dominant? (Select one)
- ○ right handed
- ○ left handed
- ○ ambidextrous (both)

Have you had any diagnostic tests done? Yes No

If yes, select all that apply.
- ☐ Xray
- ☐ CT
- ☐ MRI
- ☐ Angiogram
- ☐ VNG (videonystagmography)

Do you currently have numbness and tingling? Yes No

If yes, where? (Select all that apply)
- ☐ head/face
- ☐ right upper extremity
- ☐ left upper extremity
- ☐ right lower extremity
- ☐ left lower extremity

Additional Comments:

Home Environment

How would you rate your health? ○ excellent ○ good ○ fair ○ poor

Do you exercise regularly? ○ does ○ does not

How many falls have you had in the past 6 months? ○ 0 ○ 1 to 2 ○ >3

What is your employment status? ○ employed ○ unemployed ○ retired

What do you do for a living?

Do you live alone? ○ alone ○ with someone

Do you require assistance at home? Yes No

Do you have stairs at home? Yes No

If yes, how many? ○ 1-8 ○ 9-15 ○ >15

Where is the railing as you go up the stairs? (Select all that apply) ☐ left ☐ right

Goals/Followup

What are your goals for therapy?

When are you scheduled to return to the doctor for follow-up?
- ○ as needed
- ○ within 1 month
- ○ after completion of therapy

Additional Comments: