Rebound Sports and Physical Therapy
Vestibular and Balance Rehabilitation

Name: _____
Date of Birth: _____Age: _____
Gender: Male Female
Referring Physician: _____Primary Care Physician: _____

Describe the major problem and why you are seeing us:

When did this problem begin? _____
Specifically, do you experience spells of vertigo (a sense of spinning)? YES NO
If YES, how long do the spells last? _____
When was the last episode? _____
Is the vertigo (circle those that apply):
Spontaneous Motion induced Induced by position changes

Do you experience a sense of being off balance (disequilibrium)? YES NO
If YES, is the feeling of being off balance:
Constant? YES NO
On and off? YES NO
Induced by motion? YES NO
Induced by position changes? YES NO
Worse with fatigue? YES NO
Worse when outside? YES NO
Worse in the dark? YES NO

Does the feeling of being off balance occur when:
Lying down? YES NO
Standing? YES NO
Sitting? YES NO
Walking? YES NO

Do you or have you fallen to the ground? YES NO
If yes, when did this happen? _____
Did you/have you injured yourself in a fall? Describe: _____
Do you drift to one side when walking? YES NO
Do you have (please circle): Hearing problems? Visual problems?
What testing have you had done for your current symptoms? (circle one)
MRI Hearing/Vision test VNG Caloric test Don't know Other_____
Have you been in a serious accident lately? YES NO When? _____
Describe: _____
What medications do you take? (attach sheet if necessary) _____
_____

What activities are you no longer able to perform or have difficulty with AS A RESULT of the dizziness/vertigo or unsteadiness?
_____

Please rate you functional limitation: 0 1 2 3 4 5 6 7 8 9 10
No limitation Severe