**REBOUND SPORTS AND PHYSICAL THERAPY**

Vestibular, Post-concussion and Balance Rehabilitation Questionnaire

Name: ______________________________________ Today's Date_____________

Date of Birth: _____________Age_______________

Referring Physician: ______________________Primary Care Physician: _________________

1. Describe the major problem and why you are seeing us:

2. What are your primary symptoms? ____________________________________________________________

3. When did this problem begin?_______________________________________________________________

4. 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 changes in body position

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 |

5. What activities produce your symptoms/make them worse? ____________________________

_______________________________________________________________________________

6. 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: ____________________________

7. Do you drift to one side when walking? YES NO

8. Do you have (please circle): Hearing problems? Visual problems? History of other concussion?

If yes, how many concussions and when?_______________________________________________

9. What TESTING have you had for your current condition? (circle one)

MRI CT SCAN Hearing/Vision VNG Caloric Test Xray Congitive Tests

10. Have you been in a serious accident lately? YES NO When? _________________

    Describe: _______________________________________________________________

**CONTINUED ON BACK**

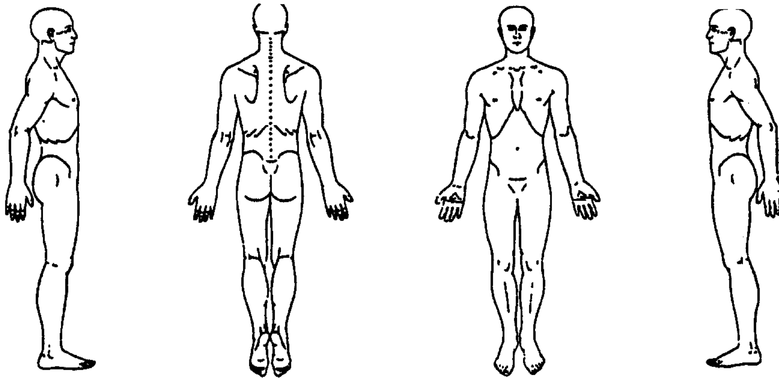
11. What activities are you no longer able to perform or have difficulty with AS A RESULT of the dizziness/vertigo, unsteadiness or post-concussion symptoms?

________________________________________________________________________________

________________________________________________________________________________

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

13. Do you have pain related to your current condition? YES NO
a. Indicate where you have pain on the diagram below:



14. What is the nature of your pain? (circle those that apply)

SHARP DULL ACHE NUMB SHOOTING BURNING TINGLING

15. Indicate the intensity of your pain: 0 1 2 3 4 5 6 7 8 9 10
(none) (worst imaginable)

16. Who have you seen for your current condition? No one MD Chiropractor PT Other

17. What is your occupation? ____________________________________________________________

18. Is there anything else you'd like us to know about your current condition?_____________________________
________________________________________________________________________________

Patient Signature ____________________________________________ Date__________________________