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?

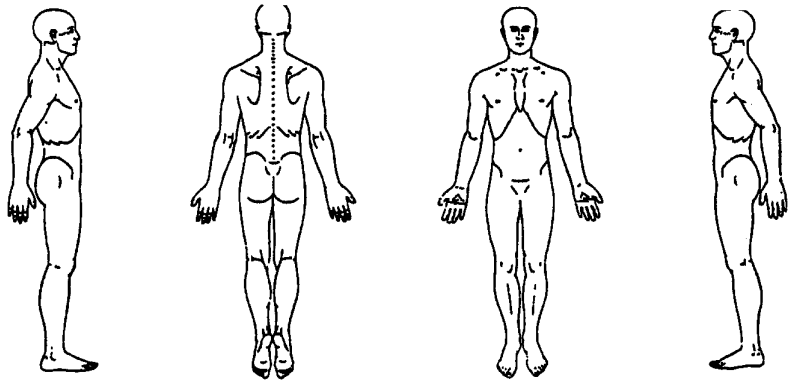
_____

_____

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_____

rebound

Sports & Physical Therapy