Sutton Place
PHYSICAL AND AQUATIC THERAPY

Name:_____ **Date:**_____

Occupation:_____ Full-time ❒ Part-time ❒ Other ❒

Primary Concern:

History of falls? No ❒ Yes ❒ If yes how often?_____ When was last fall?_____

Describe the problem that brings you to therapy: _____

_____

Date problem began:_____ Since then, has your problem: Worsened ❒ Improved ❒ Same ❒

Have you experienced a recent trauma? No ❒ Yes ❒ If yes describe_____

Have you ever experienced this problem before? No ❒ Yes ❒ If yes, please describe:_____

_____

Symptoms:

Symptom Description (circle all that apply):

LightHeadedness	Visual Disturbances	Disorientation	Hearing loss	Headaches	Rocking/ Swaying
Difficulty with Memory	Ringing in ears	Nausea Spinning	Facial Numbness		
Ear fullness/pressure	Passing out/ Fainting	Balance Difficulty	Fatigue/ weakness	Migraine	
Other:_____					

How often do symptoms occur? Daily ❒ Weekly ❒ Constantly ❒

How long do symptoms last? Seconds ❒ Minutes ❒ Hours ❒ Days ❒

Symptoms increase with (circle all that apply):

Rolling in bed	Turn head	Walking	Bearing down/Straining	Reading	Lying to sit
Look up/Down	Crowds	Lying down	Loud Noises	Sit to stand	Bending/ Squatting
Driving	Cough/Sneeze		Other:_____		

Medical History:

Circle all that Apply:

Osteoporosis	Previous Therapy	Seizure/ Epilepsy	Anemia	Cardiovascular Disease	
Arthritis	Numbness/Tingling	Asthma	Diabetes 1	Anxiety	
Head Injury/Concussion	Shortness of Breath	Diabetes 2	Depression	Thyroid Problems	
Parkinson's	Stroke	Mini-stroke	Multiple Sclerosis		
Other: _____					

Describe any items that are circled:_____

Surgical history (type/date): _____

Current Medications:

Prescriptions Vitamins

Over The Counter Herbals

List of Medications:_____

_____

_____

_____

Imaging: (X-Ray, MRI, EMG, CT scan, VNG Hearing test, etc):

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

In the last WEEK what percentage of the time has dizziness interfered with your activities? Mark on line below.

[----------]

0% 25% 50% 75% 100%

Dizziness Handicap Inventory Part 1 Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate the answer by circling “yes” or “no” or “sometimes” for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.´

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others?	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	No	Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	Yes	No	Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	No	Sometimes
P17. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes
F19. Because of your problem, is it difficult for you to walk around the house in the dark?	Yes	No	Sometimes

E20. Because of your problem, are you afraid to stay home alone?	Yes	No	Sometimes
E21. Because of your problem, do you feel handicapped?	Yes	No	Sometimes
E22. Has your problem placed stress on your relationships with members of your family or friends?	Yes	No	Sometimes
E23. Because of your problem, are you depressed?	Yes	No	Sometimes
F24. Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
P25. Does bending over increase your problem?	Yes	No	Sometimes

Part 2 Instructions: Put a check in the box that best describes you.

‰ Negligible symptoms (0)

‰ Bothersome symptoms (1)

‰ Performs usual work duties but symptoms interfere with outside activities (2)

‰ Symptoms disrupt performance of both usual work duties and outside activities (3)

‰ Currently on medical leave or had to change jobs because of symptoms (4)

‰ Unable to work for over one year or established permanent disability with compensation payments (5)