Roanoke Valley Speech and Hearing Center, Inc.

Center of Specialty Care
The American Institute of Balance®

Vestibular Testing

Patient Information

First Name:_____ Middle:_____ Last_____

Address:_____ Apt/Unit:_____

City:_____ State:_____ Zip:_____ Email:_____

Home Phone:_____ Work:_____ Cell:_____

Date of Birth:_____ Age:_____ Marital Status:_____ Gender:_____

Emergency Contact:_____ Phone #:_____ Relationship:_____

Do you live in a Skilled Nursing, Assisted Living Facility or Rehab Center? ☐ Yes ☐ No

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not employed

Employer:_____ Address:_____

Medical Doctor Information:

Referring Physician:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Family Physician:_____ Phone #:_____

Please state briefly the nature of your problem:_____

Please list operations you have had:

Operation:_____(Year/Facility/Physician):_____

Operation:_____(Year/Facility/Physician):_____

Operation:_____(Year/Facility/Physician):_____

Please name any medications you are allergic to or have been advised not to take:_____

_____

_____

Payment Information:

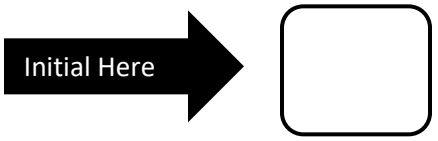
Primary Insurance:_____ ID#:_____ Group #:_____

Primary Card Holder Name:_____ Primary Card Holder Date of Birth:_____

Secondary Insurance Name:_____ ID#:_____ Group#:_____

Secondary Insurance Card Holder Name:_____ Secondary Insurance Card Holder DOB:_____

☐ I do not have insurance



☐ **I understand that I am ultimately responsible for the balance on my account for any professional services rendered**. I authorize your office to release any information relating to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Authorization for Treatment:
The patient/legal guardian authorizes **Roanoke Valley Speech & Hearing Center** to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature:_____ Date:_____

For Office Use Only:

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Medical History

Patient Name:_____ **Date:**_____

Do you currently have, or have you had, any of the following?

Neurologic
- ☐ Migraine
- ☐ Stroke/TIA
  - If so, when?_____
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Concussion/Head Injury
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic:_____

Cardiovascular
- ☐ Heart Attack
  - If so, when?_____
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Circulation Problems
- ☐ Other Cardiovascular:_____

Respiratory
- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Other Respiratory:_____

Other Health Issues:

_____

_____

_____

_____

Orthopedic
- ☐ Artificial Joints
  - If so, which?_____
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
  - If so, when?_____
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Orthopedic:_____

Vision
- ☐ Cataracts
  - If removed, when?_____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision

Other
- ☐ Tuberculosis
- ☐ Nausea
- ☐ Cancer
  - Type:_____
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Ulcer Disease
- ☐ Blood Disorders
- ☐ Tobacco Use
  - If yes, how much?_____
- ☐ Alcohol Use
  - If yes, how much?_____

Please list all of your current medications and supplements:

Prescription	Dosage	Frequency	Route	Reason

Over the Counter	Dosage	Frequency	Route	Reason

Supplements/Vitamins	Dosage	Frequency	Route	Reason

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Patient Questionnaire

Patient Name:_____ Date:_____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability, but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur?_____

How long did it last?_____

1. Do you experience any of the following sensations? Please read the entire list first, then put an "x" in either the first box for YES or in the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? ☐ Parent ☐ Sibling ☐ Child
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc?
☐	☐	Have you ever fallen? How many times?_____
		Where?_____ ☐ Inside the home ☐ Outside the home
☐	☐	Are you afraid of falling?

2. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (3).

YES	NO	
☐	☐	Is your dizziness constant? If YES, please go to section 3
		If in attacks, how often?_____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____
☐	☐	Is the dizziness worse at any particular time of day?
		If so, when?_____
☐	☐	Do you know of anything that will stop your dizziness or make it better?
		What?_____
☐	☐	Do you know of anything that will make your dizziness worse?
		What?__ _____
☐	☐	Do you know of anything that will precipitate an attack?
		What?_____
☐	☐	Do you know of any possible cause of your dizziness?
		What?_____

Patient Name:_____ Date:_____

3. Do you experience any of the following sensations? Please read the entire list first, then please check the box for either YES or NO to describe your feelings more accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensations in your head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall to the right or left?
☐	☐	Tendency to fall forward or backward?
☐	☐	Loss of balance when walking, veering to the right?
☐	☐	Loss of balance when walking, veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

4. Have your ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or In Episodes.

YES	NO			
☐	☐	Double vision?	☐ Constant	☐ In episodes
☐	☐	Blurred vision or blindness?	☐ Constant	☐ In episodes
☐	☐	Spots before your eyes?	☐ Constant	☐ In episodes
☐	☐	Numbness of face, arms or legs?	☐ Constant	☐ In episodes
☐	☐	Weakness in arms or legs?	☐ Constant	☐ In episodes
☐	☐	Confusion or loss of consciousness?	☐ Constant	☐ In episodes
☐	☐	Difficulty in swallowing? Tingling around the mouth?	☐ Constant	☐ In episodes
☐	☐	Difficulty speaking?	☐ Constant	☐ In episodes

5. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty hearing?	Both ears	Right Ear	Left Ear
		When did this start?_____ Is it getting worse?_____			
☐	☐	Does the hearing change with your symptoms? If so, how?_____			
☐	☐	Noise in your ears?	Both ears	Right Ear	Left Ear
		Describe the noise:_____			
☐	☐	Does the noise change with your symptoms? If so, how?_____			
☐	☐	Does anything stop the noise or make it better?_____			
☐	☐	Fullness or stuffiness in your ears?	Both ears	Right Ear	Left Ear
☐	☐	Does this change when you are dizzy?_____			
☐	☐	Pain in your ears?	Both ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both ears	Right Ear	Left Ear

Dizziness Handicap Inventory (DHI)

Initial Visit/ Follow-up/ Discharge

Patient Name:_____ Date:_____

Please mark an "x" in the appropriate box regarding your dizziness/imbalance symptoms.

	Yes	Sometimes	No
P1 Does looking up increase your problem?			
E2 Because of your problem, do you feel frustrated?			
F3 Because of your problem, do you restrict your travel for business or recreation?			
P4 Does walking down the aisle of a supermarket increase your problems?			
F5 Because of your problem, do you have difficulty getting into or out of bed?			
F6 Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?			
F7 Because of your problem, do you have difficulty reading?			
P8 Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
E9 Because of your problems, are you afraid to leave your home without having someone to accompany you?			
E10 Because of your problem, have you been embarrassed in front of others?			
P11 Do quick movements of your head increase your problem?			
F12 Because of your problem, do you avoid heights?			
P13 Does turning over in bed increase your problem?			
F14 Because of your problem, is it difficult for you to do strenuous homework or yard work?			
E15 Because of your problem, are you afraid people may think you are intoxicated?			
F16 Because of your problem, is it difficult for you to go for a walk by yourself?			
P17 Does walking down a sidewalk increase your problem?			
E18 Because of your problem, is it difficult for you to concentrate?			
F19 Because of your problem, is it difficult for you to walk around your house in the dark?			
E20 Because of your problem, are you afraid to stay home alone?			
E21 Because of your problem, do you feel handicapped?			
E22 Has the problem placed stress on your relationships with members of your family or friends?			
E23 Because of your problem, are you depressed?			
F24 Does your problem interfere with your job or household responsibilities?			
P25 Does bending over increase your problem?			
For office use only: **Score P:_____ E:_____ F:_____ (16-34 mild; 36-52 moderate;54+ severe)**			