Dizziness Handicap Inventory

Date:_____Patient: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes"(Y), "no"(N), or "sometimes"(S) to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

ITEM	QUESTION		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	x0	x2
	*	=			
	TOTAL				

P_____E_____F_____

□ 100-70 = severe perception of having a handicap; □ =moderate perception of handicap; □ 39-0 = low perception of handicap

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PATIENT HISTORY QUESTIONNAIRE - PT

Date _____

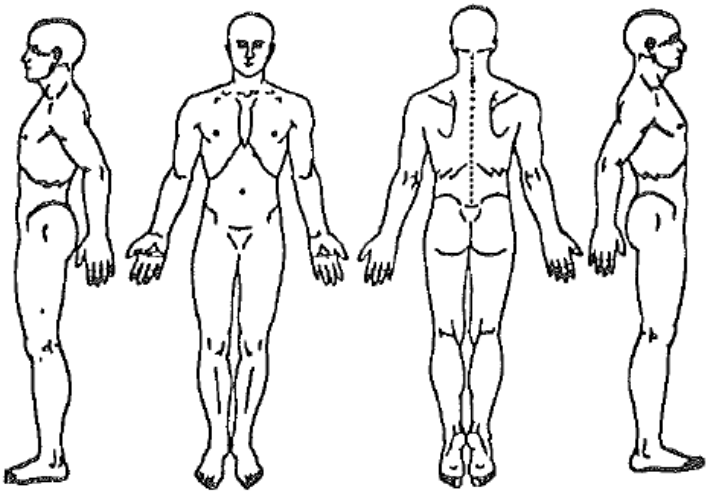
Name _____ DOB _____ Age _____ Height _____ Weight _____

Date of Next Visit with Referring Doctor _____ Family Doctor _____

Employer/Occupation _____ Leisure Activities _____

Describe the reason you are here _____

_____ Date Symptoms Began _____ Date of Surgery _____



Indicate on the diagrams, the area(s) or location(s) where you are currently experiencing symptoms, using the following key:

PPPPP = pins & needles
SSSSS = stabbing
XXXXX = burning
ZZZZZ = deep ache

Have you **EVER** been diagnosed as having any of the following conditions? Please circle.

Cancer	High Blood Pressure	Heart problems	Circulation problems	Blood Clots
Bleeding Disorder	Asthma	Hepatitis	Tuberculosis	Stomach Ulcers
Thyroid problems	Kidney problems	Depression	Diabetes	Multiple Sclerosis
Stroke	Seizures	Rheumatoid Arthritis	Chemical Dependency	
Osteoporosis	Osteoarthritis	COPD/Emphysema	Tobacco use: Y N Amt/day: _____	

Other _____

Please list any surgeries **or** other conditions for which you have been hospitalized, including the approximate date.

_____

Do you have allergies: Y N If yes, please specify _____

Please list any medications you are currently taking (prescription and over the counter). If you have a list, we would be happy to photocopy if for you.

_____

Please circle any of the following symptoms you are experiencing.

nausea/vomiting	fatigue	dizziness/lightheadedness	tremors
fever/chills/sweats	numbness or tingling	seizures	double vision
loss of vision	eye redness	skin rash	problems sleeping
sexual difficulties	hearing problems	joint/muscle swelling	easy bruising
excessive bleeding	difficulty breathing	regular cough	arm/leg swelling
heart racing in your chest	difficulty swallowing	heartburn/indigestion	post menopause
urinary incontinence	blood in urine	pregnant or think you might be	stress at home or work
weight loss/gain	bowel/bladder irregularities	abdominal pain/problems	
blood in stools	menstrual irregularities	night pain or night sweats	

If you circled any of the above, are you under a physician's care for this/these conditions? Y N

Patient Signature _____ *Thank you for taking time to complete this questionnaire.*

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PATIENT DEMOGRAPHIC INFORMATION

Date _____

First _____ **MI** _____ **Last** _____ **DOB** _____ **Age** _____

Male / Female **Married / Single / Widowed / Child** **Soc. Sec. #** _____

Home Address _____

City _____ **State** _____ **Zip** _____ **Email** _____

Home# _____ **Cell#** _____ **Work#** _____

Employer _____ **Occupation** _____

Emergency Contact _____ **Phone#** _____

How did you hear about our office? _____

IF PATIENT IS A MINOR:

Father: **Name** _____ **Phone#** _____

Mother: **Name** _____ **Phone#** _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder Name _____

Policy Holder DOB _____ Relationship _____

Secondary Insurance _____ Policy Holder Name _____

Policy Holder DOB _____ Relationship _____

HOME ADDRESS OF POLICY HOLDER if different than patient's _____

_____

Is this a liability injury? **Yes** ☐ **No** ☐ If yes, please check one: **Worker's Comp** _____ **Auto** _____ **Other** _____

Claim#: _____ **Contact Person** _____ **Phone** _____

Are you being represented by an attorney? **Yes** ☐ **No** ☐

If yes:

Attorney Name _____ **Phone** _____

Address _____

I acknowledge that I have reviewed the information listed and confirm that there are no changes to my demographic and insurance information.

Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____

Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____

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Welcome to Rock Valley Physical Therapy

Thank you for choosing Rock Valley and providing us the opportunity to work with you.
We hope to exceed your expectations and assist you in achieving your goals.

Notice of Privacy Practices:
I acknowledge being offered Rock Valley Physical Therapy's *Notice of Privacy Practices* pamphlet. I have initialed here to indicate that I understand my rights through HIPAA and that I am declining this pamphlet. (*Initial Here)* _____

Authorized Person(s):
I authorize you to speak to _____, _____, _____,

_____, _____, regarding my account and/or treatment.

By checking the box, I indicate that I do NOT want my Primary Care Physician (PCP) contacted regarding my care: ☐

Authorization to Release Information:
I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Rock Valley Physical Therapy.

Financial Responsibility:
I understand that insurance billing is a service provided as a courtesy and that I am, at all times, financially responsible to Rock Valley Physical Therapy. It is my responsibility to notify Rock Valley Physical Therapy of any changes in my health care insurance coverage. If the submitted charges or any part of them are denied for payment, I am responsible for the balance. I request that payment of my services be made on my behalf to Rock Valley Physical Therapy. I understand that by signing this form, I am accepting financial responsibility, as explained above, for payment of the balance of all medical services. I also understand that Rock Valley Physical Therapy collects for copayments at the time of service.

Supply Items:
I understand that Rock Valley Physical Therapy may, during the course of treatment, recommend purchase of a supply item. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan.

This is to verify that I have read and agree with the above.

_____ _____
Patient or Responsible Party Date

Home Address of *Responsible Party* if different than the Patient:

_____

Non-Discrimination Policy:

Rock Valley Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact the administrative assistant at (309)-743-2070. TDD/Relay Iowa.