Patient Name:_____

GAMBRILL'S PHYSICAL THERAPY

HISTORY FORM

CURRENT CONDITION/CHIEF COMPLAINT

Describe why you are seeking physical therapy? _____
_____
_____
When did it begin? _____
Was there an injury? _____
How is the problem affecting your life? _____
_____
What aggravates your symptoms? _____
How do you relieve your symptoms? _____
What are your functional goals with therapy? _____

DIZZINESS QUESTIONAIRE

Have you been diagnosed with a Vestibular Condition?_____
IF So , By Whom?_____

Circle your Symptoms

Vertigo Dizziness Lightheadiness Nausea Emesis Imbalance Falls
Headaches Changes in Hearing Ear Fullness Ringing in Ears
Changes in Eye Sight Blurriness Double Vision
Passing Out Weakness OTHER:_____

How often do you experience your symptoms: (Circle) Intermittent Constant
If intermittent: (Circle) Daily Weekly Monthly Yearly
How long do they typically last? (Circle) Minutes Hours Days Weeks

Are you symptoms brought on by Positional Changes? (Circle) YES NO
If so what positions?_____

Have any medications helped your Symptoms? (Circle) YES NO
List Medications: _____
__

Vestibular Testing Results:
When: _____ Where: _____
Do you have a copy with you? (Circle) YES NO

Other Medical Professionals that you have seen already?
_____
_____

Patient Name: _____

PAST MEDICAL HISTORY

(please check if you have or have had any of the conditions)

□Heart Problems_____	□Chemical Dependency	□Infectious Disease
□Stroke	□Depression	□Skin Disease
□High Blood Pressure	□Anxiety Disorder	□Head Injury
□Kidney Problems	□Multiple Sclerosis	□Peripheral Vascular Disease
□Seizures/Epilepsy	□Parkinson's Disease	□Lymphedema
□Osteoporosis/Osteopenia	□Anemia	□Cancer_____
□Asthma	□Blood Disorder	□Prostate Disease
□Emphysema	□Stomach Ulcers	□High Cholesterol
□Headaches/Migraines	□GERD	□Diabetes_____
□Rheumatoid Arthritis	□Osteoarthritis	□_____

Last MD Physical Examination: _____(Date)
Primary Care MD: _____
Specialist MD: _____
Date PMHX Updated:_____
Date PMHX Updated:_____
Date PMHX Updated:_____
Please list any **MEDICATIONS** including over the counter medications that you are currently taking: □See Copy_____
_____
_____
_____
ALLERGIES:_____
SURGICAL HISTORY Date
_____
_____
_____

CPR

Have your completed an advance directive for DNR (Do not resuscitate) which indicates no cardiopulmonary resuscitation (CPR) if you heart stops or if you stop breathing? □ YES □NO
If answered yes, please provide facility with copy of advanced directives.

SOCIAL/HEALTH HABITS

What is your occupation? _____
How many days a week do you exercise? _____
What type of exercise do you do? _____
Marital Status _____
Home Environment: Home/Apartment ___#Steps to enter ___#Steps to 2nd floor
Are there any religious/cultural beliefs that may affect your care that we should be aware of?
_____
Are you currently seeing anyone else for your condition?
□Acupuncturist □Chiropractor □Massage Therapist □Family Practitioner □Cardiologist □Orthopedist □ Podiatrist □Internist □Neurologist □Rheumatologist □Psychologist □OB/GYN □Pediatrician □ _____

CONTACT INFORMATION

□ I give Gambrill's Physical Therapy permission to email me regarding my physical therapy care as well as upcoming events and newsletters. EMAIL ADDRESS: _____
□ I give Gambrill's Physical Therapy permission to use this phone number for all correspondence. PHONE NUMBER :_____