VAUGHAN PHYSIOTHERAPY CLINIC

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- **Tel** (905) 669-1221
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- **Address** 398 Steeles Ave W, Unit 201, Thornhill, ON L4J 6X3

Scan for your patient portal: book, forms and receipts

Vestibular and Concussion Intake

Get better today.

For dizziness, balance problems or a concussion. Choose what applies and skip any section that does not. A parent or guardian completes this for patients under 16. Please do not drive to your appointment if you are dizzy.

Patient name *		**Date of birth ***	Y Y Y Y - M M - D D

This form is about	☐ Dizziness or balance ☐ Concussion ☐ Both
Completed by	☐ Patient ☐ Parent / guardian ☐ Other _____

A. Dizziness and balance

Skip this section if you are only here for a concussion.

What does it feel like?	☐ Spinning (vertigo) ☐ Light-headed ☐ Off balance / unsteady ☐ Rocking or swaying ☐ Visual motion ☐ Other _____		
When did it start?	Y Y Y Y - M M - D D	**How did it start?**	☐ Suddenly ☐ Gradually ☐ After injury
Pattern	☐ Constant ☐ Comes and goes ☐ Episodes / attacks	**Episodes last**	☐ Seconds ☐ Minutes ☐ Hours ☐ Days
Triggers	☐ Rolling in bed ☐ Looking up ☐ Bending over ☐ Head turns ☐ Busy places / screens ☐ Standing up ☐ Nothing ☐ Other _____		
Ear symptoms	☐ Hearing loss ☐ Ringing (tinnitus) ☐ Ear fullness ☐ None	**Which ear?**	☐ Left ☐ Right ☐ Both ☐ Not sure
Related conditions	☐ Migraine ☐ Recent cold / flu ☐ Anxiety ☐ Neck pain ☐ Vision problems ☐ Other _____		
Falls in the last 6 months	☐ None ☐ 1 ☐ 2 or more	**Do you drift to one side?**	☐ Left ☐ Right ☐ No
Dizziness today (0 to 10)	0 (None) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible)		

B. Concussion

Skip this section if you are only here for dizziness or balance.

Date of injury	Y Y Y Y - M M - D D	**How did it happen?**	☐ Sport ☐ Car accident ☐ Fall ☐ Work ☐ Other _____
At the time of injury	☐ Knocked out ☐ Memory loss ☐ Vomiting ☐ Seen in ER ☐ None of these		
Past concussions	☐ None ☐ 1 ☐ 2 ☐ 3 or more	**Sport / team**	
Coach or trainer contact		**Parent contact (under 18)**	
Headache today (0 to 10)	0 (None) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible)		
Light or noise sensitivity (0 to 10)	0 (None) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible)		
Trouble concentrating (0 to 10)	0 (None) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible)		
Fatigue (0 to 10)	0 (None) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Worst possible)		
Other symptoms	☐ Neck pain ☐ Nausea ☐ Blurred vision ☐ Sleep changes ☐ Mood changes ☐ Other _____		
School / work now	☐ Full ☐ Reduced ☐ Off ☐ Not applicable	**Activity now**	☐ Resting ☐ Light activity ☐ Training ☐ Full play

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Patient name *		Date of birth *	Y Y Y Y - M M - D D

C. Safety screen (everyone)

If you answer Yes to any of these, please call us or seek urgent care before your visit.

Sudden hearing loss in one ear?	◯ Yes ◯ No	**Face droop, slurred speech or arm weakness?**	◯ Yes ◯ No
Worst headache of your life, or getting worse?	◯ Yes ◯ No	**Repeated vomiting or seizure?**	◯ Yes ◯ No
Unable to stand or walk?	◯ Yes ◯ No	**How are you getting here?**	☐ Driving myself ☐ Driven ☐ Transit / taxi

Medications and anything else we should know	

Signature *		Date *	Y Y Y Y - M M - D D