CENTRAL OHIO℠
PRIMARY CARE
Physical Therapy

Dizziness Handicap Inventory

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please mark “always”, “sometimes” or “no” to each question. Answer each question as it pertains to your dizziness or balance problem only.

	ALWAYS	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 problem?			
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 to parties?			
F7. Because of your problem, do you have difficulty reading?			
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?			
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?			
E10. Because or your problem, have you been embarrassed in front of others?			
P11. Do quick movements of your head increase your problem?			

	ALWAYS	SOMETIMES	NO
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 housework 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 the 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 your problem placed stress on your relations 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?			

CENTRAL OHIO PRIMARY CARE

Physical Therapy

Name: _____ Today's date: _____

VESTIBULAR QUESTIONNAIRE

SYMPTOMS

What bothers you most about your dizziness/condition? _____

_____

Was your first episode of dizziness sudden or gradual? (circle one)

Are your present symptoms better, worse or same as the first episode of dizziness? (circle one)

Please describe your present symptoms without using the word "dizzy": _____

_____

What is the severity of your symptoms on a 0 to 10 scale (10 is worst)? Rate it:
presently ___/10, at worst ___/10, at best ___/10

What positions, movements or situations aggravate your symptoms? _____

_____

What is the duration of your symptoms (how long do they last)? _____

What is the frequency of symptoms (how often do they come)? _____

Do you have visual Symptoms such as double vision, increased difficulty focusing while moving your head? If so, please describe the symptoms. _____

_____

Do you have ear Symptoms such as fullness, ringing, or loss of hearing? If so, please describe the symptoms. _____

Do you have any history of previous dizziness? _____ If so, what was the treatment? _____

_____

PAST MEDICAL HISTORY AND MEDICATIONS

Do you have a history of any:

Ear surgeries? _____ If so, what type of surgery? _____

Diabetes? _____ If so, what type? _____

Neurological disorders? _____ If so, what? _____

Cardiovascular disease? _____ If so, what? _____

Do you have any feelings of depression or anxiety? _____

_____

Have you fallen since your dizziness started? If so, how many times? _____

Have you almost fallen because of your dizziness? If so, how many times? _____

In what type of housing do you currently live? (your own home, apartment, with a relative) _____

_____

What types of things could you do before your dizziness started that you are not able to do now?

_____

_____

_____

Do you currently work outside the home? If so, what type of work? _____

_____

Did you have to quit or decrease the amount of work because of your dizziness? _____

Does your dizziness cause you to sleep poorly? _____

Are you currently participating in any exercise routine? _____

Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible. _____

_____

_____

_____

_____

_____

_____

Dublin Physical Therapy
614-339-8088
Eastside Physical Therapy
614-865-3142
Northwest Physical Therapy
614-339-8081

CENTRAL OHIO
PRIMARY CARE
THE BEST FOR PRIMARY CARE

Sports, Spine and Joint Physical Therapy
614-259-0906
Westerville Physical Therapy
614-392-2812

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____

CENTRAL OHIO℠
PRIMARY CARE

Agreement of Financial Responsibility

Thank you for choosing ***Central Ohio Primary Care Physicians, Inc.*** (***COPC***) as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

Signature of Patient /Responsible Party	Date
Name of Patient/Responsible Party (please print)	Relationship to Patient