2917 Lake Shore Blvd, West.
Toronto, Ontario. M8V 1J3
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name_____ First Name_____ Initial_____

Date of Birth (*dd/mm/yyyy*) ____/____/_____ Occupation_____

Address_____ City_____ Postal Code_____

Email_____

Home Phone_____ Work Phone_____ Cell Phone _____

Direct Billing Information: Insurance Company_____

Policy Holder Last Name_____ Policy No._____

Policy Holder First Name_____ ID/Certificate No._____

For WSIB Claims Only: OHIP No. _____ WSIB Claim No._____

For Auto Insurance Claims Only: Auto Insurance Company_____

Address_____ Phone/Fax _____

Claim No. _____ Policy No._____

Date of Accident (*dd/mm/yyyy*) ____/____/_____ Adjustor Name _____

Family Physician

Name_____

Address_____

Phone_____

Fax _____

How did you hear about us?

Doctor ___ Friend ___ Media____ Walk-In____

Insurance Company_____ Family Member_____ Other_____

Referral Source's Name (*Optional*)

_____

Contact in case of Emergency

Name_____ Relationship_____

Home Phone_____ Work Phone_____

SERVICE	TOTAL FEE
Vestibular/ Concussion Assessment (45 minutes)	**$ 130.00**
Vestibular/ Concussion Treatment per unit (30 minutes)	**$ 80.00**
Vestibular/ Concussion Re-assessment ***greater than six months since last assessment or new complaint**	**$ 110.00**

N.B. Fees are subject to change.

****Our cancellation policy requires 24 hours notice or you will be charged 50% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Signature_____ **Date (*dd/mm/yyyy*)** ____/____/_____

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VESTIBULAR ASSESSMENT - QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

OCCUPATION: _____ Referring Physician: _____

Describe the major problem or reason you are seeing us: _____

When did the problem begin: _____

Have you ever experienced a sustained period of spinning vertigo? _____

Specifically, do you experience spells of vertigo (a sense of spinning?) **YES** **NO**

If **YES**, how long do these spells last? _____
When was the last time the vertigo occurred? _____
Is the vertigo:

Spontaneous	**YES**	**NO**
Induced by motion	**YES**	**NO**
Induced by position changes	**YES**	**NO**

Do you experience a sense of being off-balance (disequilibrium)? **YES** **NO**

If YES, is the feeling of being off-balance:

Constant	**YES**	**NO**			
Spontaneous	**YES**	**NO**			
Induced by motion	**YES**	**NO**			
Induced by position of change	**YES**	**NO**			
Worse with fatigue	**YES**	**NO**	Worse in the dark	**YES**	**NO**
Worse outside	**YES**	**NO**	Worse on uneven surfaces	**YES**	**NO**

Does the feeling of being off-balance occur when:

Lying down	**YES**	**NO**	Sitting	**YES**	**NO**
Standing	**YES**	**NO**	Walking	**YES**	**NO**

Do you OR have you fallen (to the ground) **YES** **NO**

If YES, please describe: _____
How often do you fall? _____
Have you injured yourself? _____

Do you stumble, stagger, or side-step while walking **YES** **NO**
Do you drift to one side while walking? **YES** **NO**

Past Medical History

Do you have:

Diabetes	**YES**	**NO**	Heart Diseases	**YES**	**NO**
Hypertension	**YES**	**NO**	Headaches	**YES**	**NO**
Arthritis	**YES**	**NO**	Neck Problems	**YES**	**NO**
Back Problems	**YES**	**NO**	Pulmonary Problems	**YES**	**NO**
Hearing Problems	**YES**	**NO**	_____		
Visual Problems	**YES**	**NO**	_____		

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Have you been in an accident? **YES** **NO** If **YES**, when: _____

If **YES,** Please describe: _____

What medication are you taking: _____

Social History

Do you live alone?	**YES**	**NO**	If **NO**, who lives with you? _____
Do you have stairs in your home?	**YES**	**NO**	If **YES**, how many? _____
Do you have trouble sleeping?	**YES**	**NO**	

Functional Status

Are you independent in self-care activities?		**YES**	**NO**			
Can you drive?	In the daytime	**YES**	**NO**	In the nighttime	**YES**	**NO**
Are you working?		**YES**	**NO**	**Not Applicable**		
Are you on Medical Disability?		**YES**	**NO**			

Are you able to:	Watch TV comfortably?	**YES**	**NO**	Read?	**YES**	**NO**
	Go Shopping?	**YES**	**NO**	Be in traffic?	**YES**	**NO**
	Work on a computer?	**YES**	**NO**	Be in a noisy place?	**YES**	**NO**

Initial Visit

For the following, please pick the on statement that best describes how you feel?

- ☐ Negligible symptoms
- ☐ Bothersome symptoms
- ☐ Performs usual work duties by symptoms interfere with outside activities
- ☐ Symptoms disrupt performance of both usual work duties and outside activities
- ☐ Currently on medical leave or had to change jobs because of symptoms
- ☐ Unable to work for over one year or established permanent disability with compensation payments

PHYSIO IN THE SIX

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Dizziness Handicap Inventory

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

	Questions	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 pleasure			
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	Do your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?			
F7	Because of your problem, do you have difficulty reading?			
F8	Does performing more ambitious activities like sports, dancing; and 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 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 housework or yard work?			
E15	Because of your problem, are you afraid people may think that 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 your problem placed stress on your relationship 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?			