DENT NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com

Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit

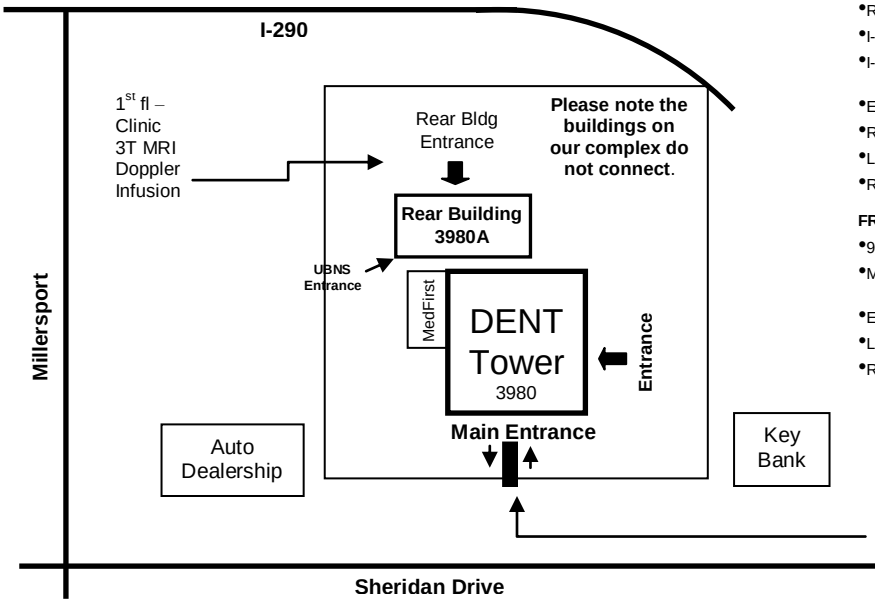
Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.

Amherst Location
3980 Sheridan Drive



FROM NIAGARA FALLS/NORTHTOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- 90 East
- Merge into I-290 (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower

1st fl - MRI, CT
2nd fl - Clinic, EMG, Dizziness Ctr
3rd fl – Pediatric, Physiatry, Pain Management
4th fl - Sleep, EEG
5th fl – Psychiatry
6th fl – Headache Center

Orchard Park

200 Sterling Drive
Orchard Park, New York 14127

FROM SOUTHTOWNS
Route 219 N to Milestrip Road East
(1st Exit onto Milestrip Road)
Left at traffic light onto Sterling Drive
Left on Red Tail
Left into parking lot

FROM BUFFALO
Thruway (90) West to Route 219
Exit Milestrip Road East
(2nd Exit onto Milestrip Road)
Left at traffic light onto Sterling Drive
Left on Red Tail
Left into parking lot

FROM PENNSYLVANIA
Thruway (90) East to Exit 56
Left onto Milestrip Road
Left onto Sterling Drive
Left on Red Tail
Left into parking lot

DENT NEUROLOGIC INSTITUTE 716.250.2000

DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:						
PATIENT INFORMATION						
Last Name:	**Middle:**	**First:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital Status (circle one):**	
					Single / Mar / Div / Sep / Wid	
Former Name:		**Birth Date:**		**Age:**	**Sex:** ❑ M ❑ F	**Transgender:** ❑ T
Street Address or P.O. Box:		**E-mail Address:**			**Home Phone: ( )**	
					Cell Phone: ( )	
City:	**State:**	**Zip Code:**			**Social Security Number:**	
Referring Physician:		**Primary Physician:**				
Occupation:	**Employer:**				**Employer Phone: ( )**	
					❑ Full Time ❑ Part Time	
Race:	**Ethnicity:**				**Language:**	
Pharmacy Name:	**Pharmacy Address:**				**Pharmacy Phone:**	
CONTACT PERSON IN CASE OF EMERGENCY						
Name:	**Relationship:**	**Home Phone: ( )**	**Work Phone: ( )**			
INSURANCE INFORMATION						
You will need to give your insurance card to the receptionist						
Person Responsible for Bill (if not self):	**Address (if different):**				**Home Phone: ( )**	
					Cell Phone: ( )	
Birth Date: / /	**Occupation:**					
Responsible Party's Employer:	**Employer Address:**				**Employer Phone: ( )**	
PRIMARY INSURANCE	**Insurance Plan:**					
Policy No:		**Group No:**				
Subscriber's Name (if not self):	**Subscriber's SSN:**				**Co-pay Amount:**	
	Subscribers DOB: / /					
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
SECONDARY INSURANCE	**Insurance Plan:**					
Policy No:		**Group No:**				
Subscriber's Name (if not self):	**Subscriber's SSN:**					
	Subscribers DOB: / /					
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU <u>MUST</u> COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus/Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

PLEASE REVIEW AND SIGN OUR PRACTICE POLICIES

Insurance Information/Assignment of Benefits…… Patients are required to provide DENT with current and accurate insurance information at every visit. Your **FAILURE** to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize DENT to furnish information to insurance carriers concerning your illnesses and treatments and hereby assign all payments for medical services rendered to you or your dependents to Dent Neurologic. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

Co-Pay, Deductibles, POS Plans, Private Payments and Unpaid Balances..…… In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your medical services. As a result, if you have a co-pay, deductible, or Point of Service Plan or you are a private paying patient, **payment is required at the time of service**. Should you need to discuss this payment policy, you may contact our Business Office at 250-2010 prior to your appointment. Please note it is within our discretion to take current payments and apply them to existing unpaid balances or move credit balances to future appointments. If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account will be turned over to a collection agency, proceedings will begin and you will be discharged from our care. Accounts sent to collections will have a 30% collection fee added to the balance along with applicable attorney fees.

Identity Theft…… The Federal Trade Commissions, "Red Flag" rule requires health care providers to establish a program to prevent identity theft. As a result we will be asking all patients to provide photo identification when checking in for their appointment and will be taking a photograph to be used for the sole purpose of identification. If you are unable to provide us with proper identification at the time of your visit, we will need to **RESCHEDULE** your appointment.

Practice Communication Information…….. Patients in our practice may be contacted via phone, email, and/or text messaging to remind of appointments, payment, treatment, and/or other healthcare information. By entering information below, you consent to receiving these communications from us:

Send reminders/information (*select all that apply*):	☐ Voice ( ) -		
	☐ SMS/text ( ) -		
	☐ E-mail address: _____ *Note: reminders not available via e-mail*		
Preferred Phone Number (**select one**):	☐ Home	☐ Cell	☐ Work
Preferred Language (**select one**):	☐ English	☐ Spanish	
Best time to contact me (**select one**):	☐ Morning	☐ Afternoon	☐ Evening
☐ I do NOT wish to receive any reminders or communications from Dent as outlined above. I understand the cancellation and no show policy as outlined below.			

Medical Photography…….. Medical photography taken for diagnostic purposes will become a part of your medical record and remain confidential in accordance with regulatory requirements and Dent policy. From time to time we may use de-identified medical imaging or photography for research or academic purposes. Dent retains all ownership rights in these programs.

Prescription Refills……..……..… Patients must contact their pharmacies to request any prescription refills for medications that DENT prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

Appointment Cancellation and No Show Policy…… Your scheduled appointment is time reserved especially for you. **We require a minimum of 24-hours advance notice for cancellation or rescheduling of an appointment to allow us to offer this time to other patients**. Rescheduling fees are: $100-Imaging, VNG, Neuropsychology, Sleep Studies. $50-All other appointments.

General Consent to Treatment and Right to Refuse Treatment..… By signing below, I (or my authorized representative on my behalf) authorize DENT Neurologic Institute and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I have read and agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.

Print Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Statement of Financial Responsibility

Insurance Coverage.* The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of DENT fees. You are ultimately responsible for payment of your bill.

Due to the increasing complexity of insurance plans, DENT requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs. For some services, DENT will collect a fee from you before the service is rendered. That amount will be credited against the cost of that service, but in many cases will not cover the full amount. Your insurance plan is the best place to find information on the ultimate cost to you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. DENT expects these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved service period, you will be responsible for your balance in full.

Your signature below will also authorize your insurer to pay any benefits directly to DENT, the full and entire amount of the bill incurred by you or the named patient, or if applicable, any amount due after payment has been made by your insurance carrier.

Co-Pay Policy. It is expected that patients will pay co-pays at the time the service is rendered for each visit, typically during check-in.

Cancellation / No Show Policy. DENT understands there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, at least 24 hours prior to the appointment time will be assessed a $50 reschedule fee (NOTE: $100 for Sleep Center, Neuropsychology testing and VNG testing appointments). All assessed fees are collected at the time of scheduling the next appointment. Patients will not be able to reschedule an appointment until all fees are paid.

By signing below, you acknowledge that you have read the above policies regarding financial responsibility to DENT for providing health care services to you or the named patient and that you understand and agree to the terms described.

Patient Name (please print): _____ DOB: _____

Patient or Guardian Signature: _____ Date: _____

*Patients with No Fault or Workers Compensation coverage will be handled in compliance with New York State law with regard to payment and benefits.

DENT NEUROLOGIC INSTITUTE

WORKERS COMPENSATION

SUPPLEMENTAL INFORMATION FORM

Today's Date:	Date of Birth:	
Patient Name:	Social Security No:	
Date of Injury:		
Employer Name:	Employer Address:	
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Carrier Claim Number:	WCB Case Number:
Name of Case Manager:	Phone: ( )
	Fax: ( )
Briefly Describe the Injury you Sustained:	
Briefly Describe how Injury Occurred:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth: Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**

FOR OFFICE USE ONLY

PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: _____**	**CLAIM# _____** **DATE OF LOSS: _____** **CARRIER: _____**

DENT NEUROLOGIC
NEW PATIENT HISTORY FORM

Today's Date _____

Name: _____ Age: _____ DOB: _____

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

_____

_____

_____

_____

_____

2a. Who is your **primary physician with address** (if known)?

_____

_____

2b. What physicians have you seen for this problem?

_____

_____

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

_____ _____

_____ _____

_____ _____

_____ _____

4. List the <u>name and dose for each</u> prescription and over-the-counter medication you are <u>currently</u> taking:

Drug: _____ **Dose:** _____

_____ _____

_____ _____

_____ _____

_____ _____

5. Any drug allergy?

<u>Drug</u> <u>Reaction</u>

_____ _____

_____ _____

_____ _____

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

Treatment	Date	Results

7. Other problems? Please **circle** the ones that apply to you:

Neurologic
Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke).

Constitutional
Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes
Blurry vision, double vision, decreased vision, cataract, glaucoma.

Ears, Nose, Mouth, Throat
Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning).

Cardiovascular
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory
Cough, emphysema, asthma.

Gastro-Intestinal
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis.

Genito-Urinary
Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems.

Skin
Rash or other skin abnormality.

Musculoskeletal
Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric
Depression, anxiety, other psychiatric problems.

Print Name: _____

Continued from # 7

Endocrine
Diabetes, thyroid problems, hormonal problems

Hematologic
Anemia, easily bruises, bleeding disorder.

Allergy
Itching, rash, swollen lips/tongue.

Have you ever had cancer? ____ No ____ Yes, describe _____

8. Have you had any of the following tests?

Test	Date	Where
MRI	_____	_____
CT	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____
SPECT/PET	_____	_____
Other (myelogram, angiogram, biopsy, spinal tap):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Do you use tobacco? ___ No ___Yes, pack per day ___, # of years____ Quit date _____

Do you use alcohol? ___ No ___ Yes, amount _____

Who lives with you at home? _____

Describe your work: _____

_____

Disability? _____ No _____ Yes, since _____

10. Have you fallen in the past 12 months? ___ No ___Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

Print Name: _____

11. Tell us about your family's health:

Mother: _____

Father: _____

Brother #1: _____ Sister #1: _____

Brother #2: _____ Sister #2: _____

Brother #3: _____ Sister #3: _____

Brother #4: _____ Sister #4: _____

12. What do you hope to achieve with your doctor?

_____

_____

_____

_____

13. Emergency contact:

Name: _____ Relationship: _____

Phone: _____ Mobile Phone:_____

_____

Print Name

_____ _____

Signature Date

Tell Us How We're Doing!
Visit Our Website at www.dentinstitute.com and take our online survey

For office use only:

BP _____ Pulse _____ Resp. _____ Wt. _____ Ht. _____

DENT NEUROLOGIC INSTITUTE •1963•

DENT
DIZZINESS, BALANCE & TINNITUS CENTER

Dizziness Questionnaire

Name: _____ DOB: _____ Date: _____

CHIEF CONCERN: Please check all the symptoms that you are currently experiencing:

□ Dizziness □ Lightheadedness □ Vertigo (spinning)
□ Imbalance □ Unsteadiness □ Falling

Describe in your own words how your dizziness or imbalance problem feels: _____

_____

HISTORY OF PRESENT ILLNESS

1. When did your problem start (date): _____ Was there any related event? □ YES □ NO
   a. If YES, check all that apply:
      □ An ear infection □ A cold
      □ Auto accident □ Other: _____
2. Was the onset of your problem: □ Gradual □ Sudden □ Overnight □ Other: _____
3. Is your dizziness/imbalance: □ Constant □ It comes and goes in spells or attacks
   a. If it comes and goes in spells or attacks:
      □ How many attacks have you experienced over the last 3 months ____ or _____ times per month?
      □ Please list a specific number for the following:
         □ They occur every # ___ hours ___ days ___weeks ___ months
         □ And they last # ___ seconds ___ minutes ___ hours ___ days ___ months
      □ Do you have any warning the attacks will occur? □ YES □ NO
         If YES, describe: _____
      □ Are you completely free of dizziness/imbalance between attacks? □ YES □ NO
4. Does your dizziness/imbalance occur with position changes? □ YES □ NO
   a. If YES, check all that apply:
      □ Rolling your body right or left □ Turning your head left or right
      □ Looking up, or head back position □ Bending over, or head down position
      □ Going from lying to sitting position □ Other: _____
5. Do you know of anything that makes your dizziness/imbalance better? □ YES □ NO
   a. If YES, check all that apply:
      □ Not moving your head □ Rest
      □ Medication: _____
      □ Other: _____
6. Do you know of anything that makes your dizziness/imbalance worse? □ YES □ NO
   a. If YES, check all that apply:
      □ Moving your head □ Riding or driving in the car
      □ Large crowds or busy walkways □ When your hungry or haven't eaten
      □ Other: _____

Print Name: _____

7. Is your dizziness/imbalance currently: □ Getting better □ Same □ Getting worse □ Variable
   a. If variable, rate the severity of your symptoms at the best times and the worst times on a scale of 1-10 with 10 being the worst. _____ Best times _____ Worst times
8. Do your symptoms limit your daily activities? □ YES □ NO
9. Do you have trouble walking in the dark or at dusk? □ YES □ NO
10. Do you have trouble walking on uneven surfaces (eg. lawn)? □ YES □ NO
11. When dizzy/imbalanced, must you support yourself to stand or walk? □ YES □ NO
    a. If YES, how do you support yourself? _____
12. Have you ever fallen due to your dizziness/imbalance? □ YES □ NO
    a. If YES, # of falls: _____ # of near falls: _____
    b. Do you tend to fall to the: □ Right □ Left □ Back □ Front □ All
13. Do you have a history of migraine headaches? □ YES □ NO
14. Did you recently get new glasses or has there been a change in your vision? □ YES □ NO
15. Have you ever had IV antibiotics or chemotherapy? □ YES □ NO

DO YOU HAVE ANY OF THE FOLLOWING EAR RELATED SYMPTOMS:

16. Do you have difficulty hearing? □ YES □ NO
    a. If YES, when did it start: _____ □ Both ears □ Right ear □ Left ear
17. Do you wear hearing aids? □ YES □ NO
18. Do you experience noise or ringing in your ears? □ YES □ NO
    a. If YES, which ears: □ Both ears □ Right ear □ Left ear
    b. Describe the noise: □ Ringing □ Buzzing □ Chirping □ Hissing □ Other
    c. Is it: □ Steady □ Pulsatile □ Constant □ Occasional
    d. Does anything stop the noise or make it better:
19. Do you have pain, fullness, or pressure in your ears? □ YES □ NO
    a. If YES, which ears: □ Both ears □ Right ear □ Left ear
    b. Does it coincide with your dizziness/imbalance? □ YES □ NO

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Indicate if constant or episodic):

Yes	No				Comments
□	□	1. Double/blurred vision or blindness	□ Constant	□ Episodic	_____
□	□	2. Numbness of face or extremities	□ Constant	□ Episodic	_____
□	□	3. Weakness in arms or legs	□ Constant	□ Episodic	_____
□	□	4. Clumsiness in arms or legs	□ Constant	□ Episodic	_____
□	□	5. Confusion or loss of consciousness	□ Constant	□ Episodic	_____
□	□	6. Difficulty with speech or swallowing	□ Constant	□ Episodic	_____

PLEASE NOTE ANY PRIOR RELEVANT EVALUATIONS, TESTS, TREATMENTS

20. Have you seen other healthcare providers for this problem? □ YES □ NO
    a. If YES, who: □ Primary MD □ Ear, Nose, Throat MD (ENT) □ Neurologist
       □ Cardiologist □ Emergency Room MD □ Physical Therapist
21. Have you had tests done for this problem elsewhere? □ YES □ NO
    - □ ENG/VNG Where: _____ When: _____ Results: _____
    - □ MRI/CT Where: _____ When: _____ Results: _____
    - □ Hearing tests Where: _____ When: _____ Results: _____
    - Other: _____

Print Name: _____ DOB: _____ Date: _____

Pre-Testing _____ Post-Therapy _____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

P1.	Does looking up increase your problem?	Yes	Sometimes	No
E2.	Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
F7.	Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E9.	Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
E10.	Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P11.	Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12.	Because of your problem, do you avoid heights?	Yes	Sometimes	No
P13.	Does turning over in bed increase your problem?	Yes	Sometimes	No
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15.	Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17.	Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18.	Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19.	Is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
E20.	Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21.	Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22.	Has your problem placed stress on your relationship with members of your family/friends?	Yes	Sometimes	No
E23.	Because of your problem, are you depressed?	Yes	Sometimes	No
F24.	Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P25.	Does bending over increase your problem?	Yes	Sometimes	No

Following Section to be Completed by Examiner

Scoring: Yes = 4 points Sometimes = 2 points No = 0 points

Functional Subscale = F — Functional Subscale: _____/36

Emotional Subscale = E — Emotional Subscale: _____/28

Physical Subscale = P — Physical Subscale: _____/30

Total Score: _____/100

Reference: Jacobson G., Newman C., The Development of the Dizziness Handicap Inventory. Arch Otolaryngology Head Neck Surgery Vol. 116, April 1990.

Patient Name: _____ Date:_____

DOB: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Name: _____ Date:_____

DOB: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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