



Vestibular & Oculomotor Physiotherapy Consent & Health History Form

This form explains vestibular and oculomotor physiotherapy and collects important health information to ensure safe and effective care.

INFORMED CONSENT

Nature of Treatment

Vestibular and oculomotor physiotherapy focuses on the assessment and treatment of dizziness, balance disorders, vertigo, and visual-movement coordination issues.

Treatment may include:

- Balance and gait training
- Eye movement (oculomotor) exercises
- Gaze stabilization exercises
- Habituation exercises for dizziness/vertigo
- Positional testing (e.g., for BPPV)
- Manual therapy (neck and related structures if appropriate)
- Education and home exercise programs
- Canalith repositioning maneuvers (if indicated)

Benefits of Treatment

Treatment may help:

- Reduce dizziness and vertigo symptoms
- Improve balance and stability
- Decrease fall risk
- Improve visual tracking and focus
- Enhance daily function and mobility

Risks & Possible Side Effects

Vestibular and oculomotor treatment is generally safe. Possible temporary effects may include:



- Dizziness or vertigo during or after treatment
- Nausea
- Fatigue
- Headache
- Temporary symptom aggravation

Symptoms may briefly increase as the body adapts to treatment techniques.

Patient Responsibilities

You agree to:

- Provide accurate and complete health information
- Inform your therapist of any changes in symptoms
- Communicate discomfort during treatment
- Follow prescribed home exercise programs

Right to Ask Questions & Withdraw Consent

You may ask questions at any time and may refuse or stop treatment at any point without affecting your future care.

Consent to Treatment

I understand the nature, benefits, and possible risks of vestibular and oculomotor physiotherapy. I voluntarily consent to assessment and treatment at MediWays Physiotherapy.

Patient Name: _____

Signature: _____

Date: _____

Parent/Guardian (if applicable): _____



HEALTH HISTORY & SYMPTOM QUESTIONNAIRE

Main Concern

What symptoms are you experiencing today?

- Dizziness
- Vertigo (spinning sensation)
- Imbalance
- Falls or near falls
- Nausea related to movement
- Visual disturbances
- Head pressure
- Motion sensitivity

Describe your main symptoms:

When did symptoms begin? _____

How often do symptoms occur?

- Constant Daily Weekly Occasional

Severity (0–10): _____

Symptom Triggers (check all that apply)

- Head movements
- Rolling in bed
- Looking up/down
- Walking or standing
- Driving
- Screens / reading
- Busy environments
- Stress or fatigue
- Sudden position changes



Medical History (check all that apply)

- Concussion / head injury
- Migraine headaches
- Stroke
- Neurological conditions
- Inner ear disorders
- High blood pressure
- Heart disease
- Diabetes
- Anxiety / panic disorder
- Vision problems
- Neck injury / whiplash
- Other: _____
- None

Medications

Are you currently taking medication? Yes No

If yes, please list:

Additional Information

- History of falls
- Use of walking aid
- Sensitivity to motion sickness

Please provide details if applicable:

Acknowledgment

I confirm that the information provided is accurate and complete. I understand it is essential for safe and effective treatment.

Patient Name: _____

Signature: _____

Date: _____