



PT/OT INITIAL EVALUATION REPORT FOR VESTIBULAR DYSFUNCTION

Today's Date: _____ Insurance Company: _____
 Patient Name: _____ Patient ID #: _____
 Date of Birth / Age: _____ Date of Onset of Symptoms: ____ / ____ / ____
 ICD-9 Code(s): _____ Diagnosis: _____
 Referring Physician Name (Specialty): _____ Referring Physician ID #: _____
 Therapy Office: _____ Discipline: PT / OT

History of present illness:

Prior Level of function:

PMH:

Medications:

Please provide information on the following tests (if done):

Hallpike - Dix:

Static balance testing:

Gaze Stabilization (VOR): _____

Dynamic balance testing:

Dizziness Handicap Inventory Score: _____

Berg Balance Scale Score: _____

Neurological/functional deficits:

Treatment Plan:

Frequency of treatment:

Therapist Signature:

Printed Name and License #: