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-10 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): _____

Dizziness Handicap Inventory Score: _____

Dynamic balance testing:

Berg Balance Scale Score: _____

Neurological/functional deficits:

Treatment Plan:

Frequency of treatment:

Therapist Signature: **Printed Name and License #:**

Created: 1/06 / Revised: 1/12, 10/15