



VOR Vestibular & Orthopaedic Rehabilitation

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Patient Name: _____

Phone: _____

Please assess and treat this patient for:

- | | |
|--|-----------------------------------|
| <input type="radio"/> Vertigo/Dizziness | <input type="radio"/> Jaw Pain |
| <input type="radio"/> BPPV | <input type="radio"/> Clicking |
| <input type="radio"/> Balance Problems | <input type="radio"/> Locking |
| <input type="radio"/> Falls | <input type="radio"/> Facial Pain |
| <input type="radio"/> Post Concussion Management | <input type="radio"/> Headaches |
| <input type="radio"/> Other | <input type="radio"/> Other |

Referring Health Care Practitioner:

Date: _____