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Vision Rehabilitation Questionnaire

Please fill out this questionnaire carefully, and if possible, return it to our office prior to the appointment. Thank you.

General Information

Patient's Name: ____

Birth Date: ______/______/________ Age: __________ years Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: ______________________________ City: ____________________ Zip: __________

Home Phone: (_______) ________ - ___________ Business Phone: (_______) ________ - ___________

Cell Phone: (_______) ________ - _____________ Email: ______________________________

Driver's License #: ______________________________ Occupation: ______________________________

Employer: ______________________________________ Phone Number: (_______) _______ - __________

Business Address: ____

Spouse's Name: ______________________________ Spouse's Occupation: ___________________________

Spouse's best number to be reached at: (_______) ________ - ___________

Were you referred to our office? ☐ Yes ☐ No

If yes, whom may we thank for this referral____

Address: ____ Phone Number: (_______) _______ - __________

Medical History

Date of Injury: ____/____/________

Type of Injury:

□ Motor Vehicle Incident □ Fall □ Blow to Head □ Industrial Accident

□ Medication-Related □ Drug Abuse/Overdose □ Drowning □ Carbon Monoxide Exposure

□ Stroke □ Cerebral Aneurysm □ Strangulation □ Poison/Toxic Substance Exposure

□ Other: ____

Which part of your head was affected *(check all that apply)*?

□ Forehead □ Right Side □ Left Side □ Back of Head □ Top of Head □ Face

Was the injury… □ *OPEN (with external bleeding)* □ *CLOSED (with no external bleeding)*

Did you lose consciousness? □ Yes □ No; If yes, for approximately how long? __________________

Were you in a coma? □ Yes □ No; If yes, for approximately how long? ______________________

Symptoms immediately following the injury *(check all that apply)*:

□ Double Vision □ Headache □ Blurred Vision □ Pain in or around the eyes

□ Dizziness □ Vomiting □ Flashes or Light □ Disorientation

□ Loss of Balance □ Neck Pain □ Loss of Memory □ Restricted Field of Vision

□ Restricted Motion □ Other: ____

Initial Treatment

On what date did you first see a doctor regarding your injury? ____/____/________

Physician's Name: ____ Specialty: ________________________________

Where were you seen?

____

Were you hospitalized? □ Yes □ No; If yes, for approximately how long? ____

What initial treatments did you receive?

____

What prognosis and/or recommendations were you given?

____

____

Subsequent Treatment

Current Physician's Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

Have you been received (or are you currently receiving) treatment from any of the following health care professionals? *(check all that apply)*:

□ Physiatrist – Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Neurologist – Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Neuropsychologist – Name: _______________________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Physical Therapist – Name: _______________________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Speech Therapist – Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Psychologist– Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Psychiatrist – Name: ____ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Osteopathic Physician – Name: ____________________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

□ Occupational Therapist – Name: ___________________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

Medications currently using, including vitamins and supplements:

____

____

For what condition(s)? ____

____

Are you allergic to any foods or medications? □ Yes □ No

If yes, please list: ____

Current Diet: □ Excellent □ Good □ Fair □ Poor

List any prior major illnesses or injuries: ____

____

Is there any history of the following *(please check all that apply)*?

	Patient	Family	Relationship		Patient	Family	Relationship
Diabetes	□	□	____________	High Blood Pressure	□	□	____________
Glaucoma	□	□	____________	Cataracts	□	□	____________
Blindness	□	□	____________	Thyroid Condition	□	□	____________
Multiple Sclerosis	□	□	____________	Strabismus	□	□	____________
Brain Tumor	□	□	____________	Amblyopia	□	□	____________
Stroke	□	□	____________	Traumatic Brain Injury	□	□	____________

Visual History

Has your vision been previously evaluated? □ Yes □ No

If yes, doctor's name: ____ Date of last exam: ____/____/________

Reason for exam: ____

Results/Recommendations: ____

Were glasses, contact lenses, or other optical devices prescribed? □ Yes □ No

If yes, what was recommended? ____

____

Are they used? □ Yes □ No If yes, when? ____

____

If not used, why? ____

____

Were any additional vision-related tests or treatments recommended?

If yes, what was recommended? ____

____

Did you undergo these tests and/or treatments? □ Yes □ No

If yes, additional Results & Recommendations: ____

____

Check the column that best represents the occurrence of each symptom.

	Never	Seldom	Occasionally	Frequently	Always
Blurry vision when looking at near objects					
Double vision					
Headaches with near work *(reading, computer use, etc.)*					
Words run together or move when reading					
Burning, itchy, or watery eyes					
Falls asleep while reading					
Vision worse at the end of the day					
Skips/repeats lines when reading					
Dizziness/nausea with near work					
Head tilt/closing one eye when reading					
Difficulty copying from chalk/whiteboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill or downhill					
Misaligns digits/columns of numbers					
Reading comprehension decreased/poor					
Poor/inconsistent in sports					
Holds reading objects too close					
Trouble maintaining attention with reading					
Difficulty completing assignments on time					
Always says “I can’t” before trying					
Avoids sports/games					
Poor hand/eye coordination and/or poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his/her time well					
Does not make change well					
Loses belongings or items					
Car/motion sickness					
Forgetful/poor memory					

Do you *CURRENTLY* experience any of the following:

	YES	NO	Present Prior to Injury
Eyes Ache			
Eyes Pull or Tug			
Difficulty Moving or Turning Eyes			
Pain with Eye Movement			
Pain In or Around Eyes			
Eye Redness			
Sensitivity to Brightness			
Difficulty Changing Focus from Far to Near			
One Eye Turns In, Out, Up, or Down			
Sensitivity to Fluorescent Light			
Patterned Wallpaper or Carpet is Bothersome			
Head Moves When Reading			
Often Lose Place When Reading			
Poor Orientation of Writing or Drawing on a Page			
Difficulty with Peripheral Vision			
Objects Appear to Jump Into and Out of Field of View			
Reduced Depth Perception			
Tunnel Vision (Narrowed Field of Vision)			
Flashes of Light			
Difficulty with Dressing			
Difficulty with Bathing or Personal Hygiene			
Difficulty Following a Series of Directions			
Difficulty Using Both Sides of the Body Together			
Dislike of Heights			
Awkward or Poor Balance			
Dizziness			
Confusion or Disorientation			
Get Lost Often			
Bothered By Noises			
Difficulty Remembering Things Heard			
Difficulty Remembering Things Seen			

Do you *CURRENTLY* experience any of the following *(continued)*:

	YES	NO	Present Prior to Injury
Difficulty Remembering the Name of Objects			
Difficulty Remembering the Names of People			
Difficulty Remembering Information Previously Known			
Difficulty Remembering Formerly Familiar People or Objects			
Difficulty Remembering Formerly Familiar People or Objects			
Difficulty Performing Tasks that were Formerly Easy or Routine			
Difficulty Performing Tasks that were Formerly Easy or Routine			
Difficulty with Time Management			
Difficulty with Numbers			
Difficulty Counting Money			

Why do you feel you need a visual evaluation today? ____

____

____

Lifestyle

Do you feel that your vision interferes with daily activities? □ Yes □ No

If yes, please explain (*please include effects on home life, work, hobbies, social activities, or personal relationships)*:

____

____

What activities comprise the majority of your daily life since your injury? ______________________________

____

What activities can you no longer engage in due to visual or other difficulties? ______________________________

____

What other changes or limitations in your daily life do you attribute to your injury? ______________________________

____

What do you hope a Visual Rehabilitation Program can do for you? ______________________________

____

Patient Preference Regarding Communication with Our Office

It is often beneficial for us to discuss examination results and to exchange information with ***other professionals involved in your care***. Please provide the information and sign below to authorize this exchange of information.

I hereby give my permission for information from, or copies of, my examination records to be forwarded to other health care providers when it is necessary for the treatment of my visual condition. I further authorize representatives of the Las Vegas Center for Vision Therapy to exchange information with other professionals involved in my care. The professionals are listed below. This authorization shall be valid for the duration of treatment or until a written request to the contrary is received.

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

In addition, if you prefer, we may discuss examination results and exchange information with ***your family member(s) and/or friend(s)*** who are involved in your care. Please provide the information and sign below to authorize this exchange of information.

I hereby give permission to the Las Vegas Center for Vision Therapy to disclose and discuss any information related to my visual and medical condition(s) with the following family member(s) and/or friend(s):

Name: ____ Relation: _________________________

Name: ____ Relation: _________________________

Name: ____ Relation: _________________________

How should we contact you?

□ Home phone □ Work phone □ Cell phone □ Cell phone Text

If we cannot reach you by telephone,

- □ Leave a message with details, including health information
- □ Leave a message with call back number only

If you provide your email address, we may contact you via email for appointment reminders, sending reports, and general correspondence. Emails are sent from our secure system; we will not send health information if you request us to do so.

The information provided on this questionnaire is current and correct to the best of my knowledge, and I hereby give my permission to the doctors and therapists at Las Vegas Center for Vision Therapy to initiate treatment.

____ ______________ ______/______/___________

Signature of patient (or parent/legal representative) *Relationship to patient* *Date*

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive visual and health evaluation to better meet your specific visual needs. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us on our secure voicemail or email. We request a minimum of 24 hours notice if you are unable to keep this appointment. Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status.