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ADULT VISION QUESTIONNAIRE (POST TBI)

Please fill out this form *carefully* and return it to our office by mail or fax prior to your appointment. Thank you.

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Were you referred to our office? Yes ☐ No ☐
If yes, who may we thank for this referral? _____
Phone: _____

What is your occupation? _____ Employer: _____

How may we contact you with information about your health? Check all that apply:
Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐
May we leave a message? Yes ☐ No ☐
What is the best number to contact you with appointment reminder calls?
Home Phone ☐ Work Phone ☐ Cell Phone ☐
May we text reminders? Yes ☐ No ☐

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High blood pressure	☐	☐	_____
Blindness	☐	☐	_____	Eye infections	☐	☐	_____
Eye turn	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Eye surgery	☐	☐	_____
Cancer	☐	☐	_____	Cataracts	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Lazy Eye	☐	☐	_____
Brain tumor	☐	☐	_____	Eye disease	☐	☐	_____

Physician's Name: _____ Date of Last Evaluation: _____
For what problem/condition? _____
Results and recommendations: _____

Medications currently using (Including vitamins/supplements):

_____

_____

For what conditions? _____

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

If yes, please list: _____

Current state of health (explain): _____

Any history in your family of an eye turn resulting from a disease or other condition?

Yes ☐ No ☐

If yes, please explain: _____

List illnesses, surgeries, high fevers, falls, etc.:

Illness	Age	Severity	Complications

VISUAL HISTORY

Do you experience any of the following:

	Yes	No	If yes, when?
Headaches	☐	☐	_____
Blurred vision	☐	☐	_____
Double vision	☐	☐	_____
Eyes tired	☐	☐	_____
Eyes hurt	☐	☐	_____
Motion sickness/car sickness	☐	☐	_____
Red or bloodshot eyes	☐	☐	_____
Watery eyes	☐	☐	_____
Bothered by light	☐	☐	_____
Closing/covering an eye to see better	☐	☐	_____
Need to hold paper close when reading or writing	☐	☐	_____
Head tilt	☐	☐	_____
Confusion of letters or words	☐	☐	_____
Skipping or omitting words	☐	☐	_____
Loss of place when reading	☐	☐	_____
Need to use finger to keep place	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Write or print poorly	☐	☐	_____
Fatigue easily	☐	☐	_____
Difficulty with short term memory	☐	☐	_____

Difficulty with long term memory	☐	☐	_____
Short attention span/loss of interest_____	☐	☐	_____
Difficulty attending to details	☐	☐	_____
Poor/awkward general motor coordination_____	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty judging distances_____	☐	☐	_____
Difficulty driving	☐	☐	_____
Dislike/avoid sports	☐	☐	_____
Difficulty hitting/judging moving targets during sports	☐	☐	_____

PREVIOUS TREATMENTS

Have you ever had a previous visual evaluation? Yes ☐ No ☐

Doctor's name: _____ Date of last visit: _____

Results and recommendations: _____

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

If yes, what? Bifocal ☐ Single vision ☐ Contact lenses ☐ Other: _____ ☐

Are they used? Yes ☐ No ☐

If yes, when are they worn? _____

If no, why not? _____

Has there been any treatment using an eye patch? Yes ☐ No ☐

If yes, please describe when the patching started and how it was done, including the age it started, the eye patched, the duration of the treatment, and an estimate of the results: _____

_____

_____

Have you ever been told that you have amblyopia (lazy eye)? Yes ☐ No ☐

Have you ever had vision therapy? Yes ☐ No ☐

If yes, Doctor's name: _____

Please describe the type of visual therapy, including duration, that age at which it was started, and an estimate of the results: _____

_____

_____

_____

_____

_____

PRIOR CONCUSSION CARE

Have you attempted any of the following treatments in the past year to treat concussion?

☐ Seeing concussion specialist Approximate date began: _____

☐ Supplements Please list: _____

☐ Glasses Number of pairs: _____ Prescribed by: _____

☐ Vision therapy Number of sessions: _____
☐ Phototherapy/Syntonics Date ended: _____
☐ Cranio-sacral therapy Number of sessions: _____
☐ Physical therapy Number of sessions: _____
☐ Vestibular testing When? _____ Results: _____
☐ Vestibular therapy Number of sessions: _____
☐ Acupuncture Number of sessions: _____
☐ Reiki Number of sessions: _____
☐ Nutritional Counseling Results: _____
☐ Massage
☐ Mild to moderate exercise
☐ Atlas orthogonal
☐ Other: _____

Is this your first concussion? Yes ☐ No ☐
List prior concussions or suspected concussions:

Age	Severe	Mild	Complications

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying? _____
How many hours daily do you spend working at near distances? _____
Are you achieving to your potential in work or school? Yes ☐ No ☐

HOBBIES/LEISURE TIME

Describe the types of activities that comprise the majority of your spare time:

_____
_____
_____

Do you watch TV? Yes ☐ No ☐
If yes, how many hours per day? _____ How many days per week? _____
Are you seriously involved with athletics? Yes ☐ No ☐

Do you feel your vision limits your or prevents you from participating in any activities?

Yes ☐ No ☐

If so, explain what and how: _____

_____

Is there any other information that you feel would be helpful in our evaluation and treatment?

Release of Information:

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

I authorize the release of medical information to other health care providers upon their written request, or upon the recommendation of VISIONARY OPOMETRY when it is necessary for the treatment of my visual condition. This authorization shall be considered valid for the duration of my treatment.

_____ _____

Signature of patient or authorized representative Date