NORMAN A. ROSE, O.D. INC.

41593 Winchester Road
Suite 200
Temecula, CA 92590

Email: doctorrose@cox.net **Phone/Fax: (760)746-0570**

www.stroke-neurorehab.com

NEURO-OPTOMETRIC REHABILITATION QUESTIONNAIRE
Please fill out this form carefully and return it one week before your appointment.

Today's Date: _____ Cell Phone: ( ) _____

Home Phone: ( ) _____ Work Phone: ( ) _____

O Mr. O Mrs. O Miss O Ms O Child Email Address _____

Patient's Name:_____ Nick Name: _____

Address: _____

City _____ State _____ Zip _____

Birthday: _____ Parent(s) / Guardian (If a child) _____

Patient's Occupation:_____

Employer: _____

Primary Medical Insurance: _____ ID# _____

Secondary Medical Insurance: _____ ID# _____

Social Security # _____ Driver's License # _____

Primary Care Doctor: _____ Office Phone:_____

Insured's Name (if different form patient) _____ ID# _____

Insured's Birthday: _____ Insured's Employer _____

Who can we thank for referring you to our office? _____

A. NEUROLOGICAL HISTORY

Date of injury / accident: _____

Type of injury / accident: Motor Vehicle O Stroke O Fall O Blow to head O Industrial Accident O
Medication-related O Drug abuse O Poison or toxic substance O Carbon dioxide O
Drowning O Cord around neck O Aneurysm O Hemorrhage O

Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead O Right Side O Left O Back of head O Top of head O Face O

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Did you lose consciousness? Yes O NO O If yes, for how long? _____

Were you in a coma? Yes O No O If Yes , how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT / INJURY: (check that apply)

Double vision O Headache O Blurred vision O Pain in or around eyes O Dizziness O Vomiting O
Flashes of light O Disorientation O Loss of balance O Neck pain/ whiplash O Loss of memory O
Restricted field of view O Restricted motion O

Other: _____

INTIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____

Name of Doctor: _____ Specialty: _____

Where were you seen? _____ Were you hospitalized? Yes O No O How long O ___

What were you and your family told? _____

What did the initial treatments consist of? _____

What prognosis/recommendations were you given? _____

Were you given medications? Yes O No O Medication: _____

_____

For what condition(s)? _____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and described):

Physicians Name: _____ Date: _____

Results and recommendations: _____

Physiatrist Name: _____ Date: _____

Results and recommendations: _____

Neurologist Name: _____ Date: _____

Results and recommendations: _____

Neuropsychologist Name: _____ Date: _____

Results and recommendations: _____

Physical Therapist Name: _____ Date: _____

Results and recommendations: _____

Speech / Language Therapist Name: _____ Date: _____

Results and recommendations: _____

Psychologist / Psychiatrist Name: _____ Date: _____

Results and recommendations: _____

Osteopathic Physicians Name: _____ Date: _____

Results and recommendations: _____

Other / Name: _____

Results and recommendations: _____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes O No O

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

Were glasses, contact lenses or other optical devices recommended? Yes O No O

If yes, what? _____

Are they used? Yes O NO O If yes, when? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes O No O If yes, what? _____

Did you undergo these treatments? Yes O NO O Explain: _____

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Also present before Injury?
Eye redness	O	O	O
Burning eyes, watery eyes or itchy eyes	O	O	O
Feeling that something is in the eyes	O	O	O
Blurred vision	O	O	O
Double vision	O	O	O
Squinting, covering or closing one eye	O	O	O
Headaches	O	O	O
Perceived movement of objects or patterns	O	O	O
Eye strain or ache	O	O	O
Hallucinations	O	O	O
Increased sensitivity to lights	O	O	O
Staring Behavior	O	O	O
Difficulty with balance	O	O	O
Difficulty with coordination	O	O	O
Difficulty with posture	O	O	O
Difficulty with attention	O	O	O
Difficulty with concentration	O	O	O
Memory seems worse	O	O	O
Lose place often while reading	O	O	O
Skip words frequently when reading	O	O	O
Movement of objects in the environment is bothersome	O	O	O
Pattern wallpaper or carpet is bothersome	O	O	O
One eye turns in, out, up or down	O	O	O
Difficulty changing focus from far to near	O	O	O
Head tilts left or right	O	O	O
Loss of side vision	O	O	O
Floor seems tilted	O	O	O
Wall or floor seems to shift or move	O	O	O
Leaning toward one side	O	O	O
Veering to the left or right when walking	O	O	O
Paralysis on one side of your body	O	O	O
Dizziness or disequilibrium	O	O	O
Vertigo	O	O	O
Anxiety or panic attacks	O	O	O
Difficulty with sleeping, insomnia	O	O	O
Depression	O	O	O
Irritability	O	O	O
Increase sensitivity to noise and light	O	O	O
Brain fog	O	O	O
Difficulty with judging distances	O	O	O

	Yes	No	Also present before Injury?
Difficulty with dressing	O	O	O
Difficulty with bathing/personal hygiene	O	O	O
Difficulty following a series of directions	O	O	O
Difficulty using both sides of the body together	O	O	O
Dislike heights	O	O	O
Get lost often	O	O	O
Bothered by noise	O	O	O
Bothered by touch	O	O	O
Difficulty remembering things heard	O	O	O
Difficulty remembering things seen	O	O	O
Difficulty remembering name of objects	O	O	O
Difficulty remembering people's names	O	O	O
Difficulty recalling information known in the past	O	O	O
Difficulty remembering formerly familiar people / object	O	O	O
Difficulty performing tasks formerly easy / routine	O	O	O
Difficulty with time management	O	O	O
Difficulty with numbers	O	O	O
Difficulty counting money	O	O	O

Which of the symptoms above seem to be the most bothersome for you?_____

_____

Why do you feel the need for a neuro-optometric rehabilitation evaluation today?_____

_____

_____

_____

LIFESTYLE:

Do you feel your vision interferes with activities of daily living? Yes O NO O

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships):

_____

_____

_____

What activities comprise the majority of your daily life since your accident / injury?_____

_____

_____

What activities, other changes / limitations in your daily life do you attribute to your accident / injury?

_____

_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	O	O	O
INTEGUMENTARY (Skin)	O	O	O
NEUROLOGICAL			
Headaches	O	O	O
Migraines	O	O	O
Seizures	O	O	O
EYES			
Loss of vision	O	O	O
Blurred Vision	O	O	O
Distorted Vision / Halos	O	O	O
Loss of Side Vision	O	O	O
Double Vision	O	O	O
Dryness	O	O	O
Mucous Discharge	O	O	O
Redness	O	O	O
Sandy or Gritty Feeling	O	O	O
Itching	O	O	O
Burning	O	O	O
Foreign Body Sensation	O	O	O
Excess Tearing/ Watering	O	O	O
Glare / Light Sensitivity	O	O	O
Eye Pain or Soreness	O	O	O
Chronic Infection of Eye or Lid	O	O	O
Sties or Chalazion	O	O	O
Flashes / Floaters in Vision	O	O	O
Tired Eyes	O	O	O
ENDOCRINE			
Thyroid	O	O	O
Other Glands	O	O	O

	NO	YES	?
EARS, NOSE, MOUTH THROAT			
Allergies / Hay Fever	O	O	O
Sinus Congestion	O	O	O
Runny Nose	O	O	O
Post-Nasal Drip	O	O	O
Chronic Bronchitis	O	O	O
Dry Throat / Mouth	O	O	O
RESPIRATIORY			
Asthma	O	O	O
Chronic Bronchitis	O	O	O
Emphysema	O	O	O
VASCULAR / CARDIOVASCULAR			
Diabetes	O	O	O
Heart Pain			
High Blood Pressure	O	O	O
Vascular Disease	O	O	O
GASTROINTESTINAL			
Diarrhea	O	O	O
Constipation	O	O	O
GENITOURINARY			
Genitals / Kidney / Bladder	O	O	O
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	O	O	O
Muscle Pain	O	O	O
Joint Pain	O	O	O
LYMPHATIC / HEMATOLOGIC			
Anemia	O	O	O
Bleeding Problem	O	O	O
ALLERGIC / IMMUNOLOGIC	O	O	O
PSYCHIATRIC	O	O	O

Allergies to medication: _____

Current medications: _____

_____

_____

Family History

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	O	O	O	_____
Cataract	O	O	O	_____
Crossed Eye	O	O	O	_____
Amblyopia	O	O	O	_____
Glaucoma	O	O	O	_____
Macular Degeneration	O	O	O	_____
Retinal Detachment / Disease	O	O	O	_____
Arthritis	O	O	O	_____
Cancer	O	O	O	_____
Diabetes	O	O	O	_____
Heart Disease	O	O	O	_____
High Blood Pressure	O	O	O	_____
Kidney Disease	O	O	O	_____
Lupus	O	O	O	_____
Thyroid Disease	O	O	O	_____
Other _____	O	O	O	_____

SOCIAL HISTORY:

Education: How many years of school have you completed? _____

Occupation: Your current employment status is: O Retired O Unemployed O Homemaker O Employed

Current occupation: _____

Disability: Are you disabled? O YES O NO

Marital Status: Are you currently married? O NO O YES If yes, how many years have you been married? _____

Spouse: O Not Applicable O Alive, age? _____ O Deceased

Do you use tobacco products? O NO O YES If yes, type / amount/ how long: _____

Do you drink alcohol? O NO O YES If yes, type / amount/ how long: _____

Do you use recreational/street drugs? O NO O YES If yes, type / amount/ how long: _____

What is current employment position? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent reading / studying? _____

How many hours daily are spent with a computer? _____

REPORT POLICIES

Would you like copies of any reports? O Yes O No

Would you like copies of any reports sent to anyone else? If so, please list name and address. _____

_____

Please sign below to give us permission to release information to the above sources. (Valid for 90 days only)

Signed _____ Date _____

I, _____understand that I/MY dependents are eligible for _____ Insurance through MY/SPOUSE'S Employment. I am aware that if the above is not true, I or the person financially responsible for me, are responsible for all charges related to services provide to me. I agree that if the above is not true, I or the person financially responsible will pay in full for all such charges.

_____

Signature

_____

Date