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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: () _____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ 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 from 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 ☐ Stroke ☐ Fall ☐ Blow to head ☐ Industrial Accident ☐
Medication-related ☐ Drug abuse ☐ Poison or toxic substance ☐ Carbon dioxide ☐
Drowning ☐ Cord around neck ☐ Aneurysm ☐ Hemorrhage ☐

Other: _____

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

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

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

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

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

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

Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐ Dizziness ☐ Vomiting ☐

Flashes of light ☐ Disorientation ☐ Loss of balance ☐ Neck pain/ whiplash ☐ Loss of memory ☐

Restricted field of view ☐ Restricted motion ☐

Other: _____

INITIAL TREATMENT

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

Name of Doctor: _____ Specialty: _____

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

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 ☐ No ☐ 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 ☐ No ☐

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

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

If yes, what? _____

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

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

Yes ☐ No ☐ If yes, what? _____

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

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

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

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

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 ☐ NO ☐

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	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH THROAT		
Fever, Weight Loss / Gain	☐	☐	☐		Allergies / Hay Fever	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐		Sinus Congestion	☐	☐
NEUROLOGICAL					Runny Nose	☐	☐
Headaches	☐	☐	☐		Post-Nasal Drip	☐	☐
Migraines	☐	☐	☐		Chronic Bronchitis	☐	☐
Seizures	☐	☐	☐		Dry Throat / Mouth	☐	☐
EYES					RESPIRATORY		
Loss of vision	☐	☐	☐		Asthma	☐	☐
Blurred Vision	☐	☐	☐		Chronic Bronchitis	☐	☐
Distorted Vision / Halos	☐	☐	☐		Emphysema	☐	☐
Loss of Side Vision	☐	☐	☐		VASCULAR / CARDIOVASCULAR		
Double Vision	☐	☐	☐		Diabetes	☐	☐
Dryness	☐	☐	☐		Heart Pain		
Mucous Discharge	☐	☐	☐		High Blood Pressure	☐	☐
Redness	☐	☐	☐		Vascular Disease	☐	☐
Sandy or Gritty Feeling	☐	☐	☐		GASTROINTESTINAL		
Itching	☐	☐	☐		Diarrhea	☐	☐
Burning	☐	☐	☐		Constipation	☐	☐
Foreign Body Sensation	☐	☐	☐		GENITOURINARY		
Excess Tearing/ Watering	☐	☐	☐		Genitals / Kidney / Bladder	☐	☐
Glare / Light Sensitivity	☐	☐	☐		BONES / JOINTS / MUSCLES		
Eye Pain or Soreness	☐	☐	☐		Rheumatoid Arthritis	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐		Muscle Pain	☐	☐
Sties or Chalazion	☐	☐	☐		Joint Pain	☐	☐
Flashes / Floaters in Vision	☐	☐	☐		LYMPHATIC / HEMATOLOGIC		
Tired Eyes	☐	☐	☐		Anemia	☐	☐
ENDOCRINE					Bleeding Problem	☐	☐
Thyroid	☐	☐	☐		ALLERGIC / IMMUNOLOGIC	☐	☐
Other Glands	☐	☐	☐		PSYCHIATRIC	☐	☐

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	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eye	☐	☐	☐	_____
Amblyopia	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment / Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

SOCIAL HISTORY:

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

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

Current occupation: _____

Disability: Are you disabled? ☐ YES ☐ NO

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

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

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

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

Do you use recreational/street drugs? ☐ NO ☐ 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? ☐ Yes ☐ 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