all ages vision care OD, PA
learning-related vision specialists

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VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided or fax it to 704-405-1225. THANK YOU.

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

GENERAL INFORMATION

Patient's Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Work/Cell Phone: _____
Email Address: _____
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If yes, who is the carrier? _____ Policy #: _____
Does the insurance cover eye examinations or glasses? Yes ☐ No ☐
Primary Insurance: _____ Policy #: _____
What is your occupation? _____ Employer: _____
Business Address: _____
Spouse's/Parents' Name(s): _____ Occupation: _____
Spouse's/Parents' Employer: _____ Phone #: _____
Business Address: _____

MEDICAL HISTORY

Date of injury/accident (if applicable): _____
Type of injury/accident: Motor vehicle ☐ Fall ☐ Blow to head ☐ Industrial Accident ☐
Medication-related ☐ Drug abuse ☐ Poison or toxic substance ☐ Carbon dioxide ☐
Drowning ☐ Cord around neck ☐ Stroke ☐ Aneurysm ☐ Hemorrhage ☐
Other: _____

WHAT 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 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 all 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/symptoms? _____
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)? _____
List any medications, including vitamins and supplements used at the current time: _____

_____

SUBSEQUENT/OTHER PROFESSIONALCARE

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

Physician 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 Physician Name: _____ Date: _____
Results and recommendations: _____
Other/Name: _____ Date: _____
Results and recommendations: _____

Do you have a history of allergies? Yes ☐ No ☐
If yes, please explain: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____
Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____
Has a speech and language evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____

MEDICAL HISTORY

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

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	_____	Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____	Cataracts	☐	☐	_____
Thyroid condition	☐	☐	_____	Blindness	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Strabismus	☐	☐	_____
Brain Tumor	☐	☐	_____	Amblyopia	☐	☐	_____
Stroke	☐	☐	_____	Traumatic brain injury	☐	☐	_____

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? _____

If no, why not? _____

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 <u>CURRENTLY</u> EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Eyes ache	☐	☐	☐
Eyes pull or tug	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Eyes twitch	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Motion sickness/car sickness	☐	☐	☐
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐

	Yes	No	Prior to Injury?
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of interest/concentration when doing close work	☐	☐	☐
Orient writing/drawing poorly on page	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Hold books too close	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision/Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Difficulty with dressing	☐	☐	☐
Difficulty with bathing/personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion/disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Bothered by noises	☐	☐	☐
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/objects	☐	☐	☐
Difficulty performing tasks formerly easy/routine	☐	☐	☐

	Yes	No	Prior to Injury?
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

Why do you feel the need for a vision 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/symptoms? _____

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment/education (school name & grade) position? _____
If a student, what is the major course of study? _____
How many hours daily are spent at a desk? _____
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? _____

Release of Information and Insurance Filing:

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 or insurance carriers upon their written request, or upon the recommendation of the All Ages Vision Care, OD, PA when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

_____ _____

Signature of patient or authorized representative 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 evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day, 7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status. Please mail this completed form to: All Ages Vision Care, Attn: Wendy Hartman, 6917 Shannon Willow Rd, Suite 100, Charlotte, NC 28226-1333 or fax it to 704-405-1225.

Thank you.

Sincerely,

Genia G. Beasley, O.D., F.C.O.V.D., F.A.A.O.
Fellow, College of Optometrists in Vision Development
Fellow, American Academy of Optometry
Clinical Director