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# VISION REHABILITATION QUESTIONNAIRE

***Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.***

***THANK YOU!***

Date _____

Patient's Name: _____

## GENERAL INFORMATION

Patient Name: _____ Male ☐ Female ☐

Birth Date: _____ Age: _____

Home Address: _____

Home/Cell Phone: _____ Work Phone: _____

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: _____

## RESPONSIBLE PERSON INFORMATION

Name: _____ Relation to patient: _____

Home Address: _____ City: _____ Zip: _____

Home/Cell Phone: _____Work Phone: _____

## MEDICAL HISTORY

Date of injury/accident: _____

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? _____

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):

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: _____ 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 CURRENTLY 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 | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ |

| | Yes | No | Prior to Injury? |
|---|---|---|---|
| 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 | ☐ | ☐ | ☐ |

| | Yes | No | Prior to Injury? |
|---|---|---|---|
| Difficulty performing tasks formerly easy / routine | ☐ | ☐ | ☐ |
| 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? _____

_____

_____

_____

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? _____

_____

_____

_____

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

_____

_____

**EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)**

What is current employment 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? _____