CIMARRON FAMILY VISION CENTER ● 6602 E CARONDELET DR ●TUCSON AZ 85710
Phone (520) 886-8800 ● Fax (520) 886-8805 ● email: visiontherapy@live.com

BRAIN INJURY AND VISION REHABILITATION QUESTIONNAIRE

(Please fill out the questionnaire carefully.)

Patient Name: _____ Date of Birth: _____

Why do you feel the need for a vision evaluation today? _____

_____

_____

GENERAL INFORMATION

Parent/ Guardian Names: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____

Whom may we thank for this referral? _____ Phone: _____

MEDICAL HISTORY

Date of injury/accident: _____
Type of injury/accident (circle):

Motor vehicle	Toxic substance
Fall	Stroke / Aneurysm / Hemorrhage
Blow to head	Other:

Please explain: _____

_____

WHAT PART OF THE HEAD WAS AFFECTED? _____
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____
Was there loss of consciousness? Yes ☐ No ☐ If yes, for how long? _____
Was there a coma? Yes ☐ No ☐ If yes, how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (circle all that apply)

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

INITIAL TREATMENT

When was a doctor first seen regarding the injury? _____

Name of Doctor: _____ Specialty: _____

Where? _____ Were you/your child 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 medications given? Yes ☐ No ☐ Medication(s): _____

For what condition(s)? _____

_____

OTHER PROFESSIONAL CARE

Physicians Name: _____

Results and recommendations:

Neurologist Name: _____

Results and recommendations:

Psychologist / Psychiatrist Name: _____

Results and recommendations:

Physical Therapist Name: _____

Results and recommendations:

Speech / Language Therapist Name: _____

Results and recommendations:

Other / Name: _____

Results and recommendations:

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	☐	☐	_____

Other:

_____

Is there a history of allergies? Yes ☐ No ☐

If yes, please explain: _____

List any medications, including vitamins and supplements used at the current time: _____

_____

VISUAL HISTORY

Is there a previous vision evaluation? Yes ☐ No ☐

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

DID 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	☐	☐	☐
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	☐	☐	☐

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

LIFESTYLE

Do you feel that the vision interferes with activities of daily living? Yes ☐ No ☐

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

_____

_____

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

_____

_____

What activities can you/your child no longer engage in due to the visual difficulties? _____

_____

_____

What other changes/limitations in daily life that can be attributed to the injury? _____

_____

_____

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

_____

RELEASE OF INFORMATION

It is often beneficial to 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 agree to permit information from, or copies of, my examination records to be forwarded to other health care providers upon their written request or upon the recommendation of Cimarron Family Vision when it is necessary for the treatment of my visual condition. I authorize Dr. Amy Thomas and Cimarron Family Vision Staff to exchange information with other health care professionals involved in my care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

I hereby authorize Cimarron Family Vision to release copies of the reports to the names stated in the questionnaire and also provided below unless expressly forbidden at the end of the page.

_____ _____

Patient Name (print) Relationship to patient (if minor)

_____ _____

Patient/Legal Guardian Signature Date

Please list below everyone that you would like to receive evaluation and treatment information.

_____ _____

Optometrist Phone

_____ _____

Therapist Phone

_____ _____

Teacher/School Phone

_____ _____

Pediatrician Phone

_____ _____

Other Phone

_____ _____

Other Phone

I wish to withhold my evaluation and treatment information from the following individuals:

_____ _____

Name Relationship to patient

_____ _____

Name Relationship to patient

PERMISSION TO PHOTOGRAPH/VIDEOTAPE

We may need to photograph or videotape you for our records. This photograph will not be used for any other purpose without your express permission.

Will you allow permission to photograph and/or videotape?

Yes / No

Signature: _____

I hereby give my permission to Cimarron Family Vision to treat: _____
(Name)

_____ _____
Signature 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 of you and to better meet your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us at any time. We request a minimum of 48 hours' notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status.

THANK YOU.

Sincerely,

Amy Thomas, OD, FCOVD
Developmental/Neurocognitive Optometrist

NOTE: ***While Optometric Vision Therapy is not inexpensive, it should be seen as an investment in your/your child's future.***

Realizing that the cost of vision therapy may be a financial burden for some families, Cimarron Family Vision has made special arrangements with CareCredit (www.carecredit.com). Please do not hesitate to discuss this with the office manager.

For more information on insurance coverage, please visit our website at: www.cimarronfamilyvision.net