learn to see
vision clinic

Welcome to our office!
History Form for Traumatic Brain Injury

Please fill out the background history form *as completely as possible* and return to the office **before** your appointment. **Thank you! We look forward to serving you.**

Name _____Birth date_____/_____/_____ Age_____

Address_____

City _____State_____Zip _____

Email Address_____

Home Phone _____Cell Phone_____

Occupation_____ Work Phone_____

Others living at home with you_____

Parents name, email, and phone number (if patient is a minor or otherwise financially supported by parents)

_____

Vision and Rehabilitation History

Date of Injury_____/_____/_____

Describe the nature of your injury_____

Who referred you for a neuro- visual evaluation? _____

In what ways does your vision cause you difficulty? _____

_____

_____

How has your traumatic brain injury affected your work or school performance?

_____

What have you done so far in your rehabilitation? _____

_____

Previous visual examinations (list reason for exams and results) _____

_____

Please fill out the attached Symptoms Checklist for Traumatic Brain Injury

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General Health History

Describe your health history and any serious illnesses. _____

_____

List any medications you are currently taking: _____

Allergies _____

Permission for Release of Information

In an effort to communicate with the professionals who care for our patients' health, the Learn to See Vision Clinic would like to send copies of your vision evaluation and follow up reports to any of the following professionals.

Please provide the name, address, phone, fax and email of the professionals for which you permit reports to be sent. Complete information is required to ensure we can best serve you.

- **Name of rehabilitation provider/physician and clinic**

  _____
  Phone:_____Fax:_____
  Mailing Address:_____
  Email:_____

- **Other therapists and clinic (occupational therapy physical therapy, and speech)**

  _____
  Phone:_____Fax:_____
  Mailing Address:_____
  Email:_____

- **Other medical specialists (neurologist, neuropsychologist, chiropractor)**

  _____
  Phone:_____Fax:_____
  Mailing Address:_____
  Email:_____

At any time you have the right to decline the disclosure of your patient health information. At the time of declination the Learn to See Vision Clinic will cease to use your health information unless otherwise required by law. I understand the above and give my permission to disclose my health vision evaluation to the appropriate medical and educational professionals.

_____
Signature Date

Payment is fee for service due at the time of your appointment. If a third party is being billed (health insurance, auto insurance, workers comp, etc.), the patient will be required to have credit card information on file in the event that coverage is denied.

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Symptoms Checklist for Traumatic Brain Injury

Name_____**age**_____
Date_____**DOI**_____

Rate each symptom 0=never 1=seldom 2=occasionally 3=frequently 4=always

Headaches	0	1	2	3	4	
Light sensitivity	0	1	2	3	4	
Double vision, doubled or overlapping words	0	1	2	3	4	
Blurred vision	0	1	2	3	4	
Difficulty changing between near and far vision	0	1	2	3	4	
Covering or closing one eye to see more clearly	0	1	2	3	4	
Eye strain or pain	0	1	2	3	4	
Losing place when reading	0	1	2	3	4	
Words move or run together when reading	0	1	2	3	4	
Comprehension problems when reading	0	1	2	3	4	
Disordered thinking	0	1	2	3	4	
Forgetful or poor memory	0	1	2	3	4	
Sensory sensitivity (sights, sounds, touch)	0	1	2	3	4	
Spatial disorientation	0	1	2	3	4	
Sensitive to motion in the periphery	0	1	2	3	4	
Difficulty in busy visual environments (mall/supermarket/school)	0	1	2	3	4	
Reduced peripheral vision	0	1	2	3	4	
Balance issues, dizziness	0	1	2	3	4	
Nausea and/or vomiting	0	1	2	3	4	
Motion sickness	0	1	2	3	4	
Physical fatigue	0	1	2	3	4	
Sleep disturbances	0	1	2	3	4	
Increase in emotions or irritability	0	1	2	3	4	
Difficulty with nighttime driving	0	1	2	3	4	
Stress/anxiety	0	1	2	3	4	

Add the numbers from each line to find a final score **Total Score**_____

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