Vision Therapy Centers, SC
1466 Kenwood Dr.
Menasha, WI 54952

Dr. Linda Dejmek O.D.,FCOVD
Neuro-Developmental
Optometrist

Office: 920-722-2020
Toll Free: 888-613-2020
Fax: 920-722-2022

email: info@abseevision.com

Neuro History (Adult)

Date_____ Completed By_____

How did you learn about A B See?_____

General Information

Patient's name

_____
(LAST) (FIRST) (M)

Birth Date_____ Age_____ Gender F M

Home Address_____

_____

City_____ State_____ Zip_____

E-mail _____

Home Phone___(____)_____

Cell Phone____(____)_____

Fax number ___(____)_____

What is or was your occupation?_____

Employer_____

Work Address_____

_____

City_____State_____Zip_____

Work Phone___(____)_____

May we contact you at your business ? Yes ☐ No ☐

If married, name of spouse

_____
(Last) (First) (M)

Cell Phone____(____)_____

E-mail_____

Occupation_____

Employer_____

Work Phone___(____)_____

Patient's Insurance Information

Primary Health Care Plan_____

Medical Billing Address_____

_____

Policy Holder_____

Policy Number_____Group #_____

Emergency contact_____

Caregiver_____

Please bring this form to your (or your child's) appointment. This assists us in determining the visual performance tests needed. If your child has an Individual Education Plan (IEP), or other testing which we should be aware of, please provide a copy.

Please check any of the following professionals that you have seen related to your injury:

- ☐ Physiatrist
- ☐ Neurologist
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Massage Therapist
- ☐ Ophthalmologist
- ☐ Audiologist/Otolaryngologist
- ☐ Chiropractor
- ☐ Other_____
- ☐ Family Physician
- ☐ Speech Therapist
- ☐ Physical Therapist
- ☐ Neuropsychologist
- ☐ Emergency Room Doctor
- ☐ Occupational Therapist
- ☐ Osteopath

Initial Treatment

First treatment date:_____

Name of Doctor:_____

Where were you seen?

Office_____

Hospitalized ☐ Yes ☐ No

How Long?_____

Initial treatment consisted of:_____

What prognosis/recommendations were you given?

Subsequent/Current Professional Care

What types of professional care have you received or are you currently receiving?
(Check all that apply and describe)

Physician Name:

Location:
Results/Recommendations:

Neurologist Name:

Location:
Results/Recommendations:

Physical Therapist Name:

Location:
Results/Recommendations:

Speech/Language Therapist Name:

Location:
Results/Recommendations:

Psychologist/Psychiatrist Name:

Location:
Results/Recommendations:

Optometrist/Ophthalmologist Name:

Location:
Results/Recommendations:

Other/Name:

Location:
Results/Recommendations:

Was the head Trauma:

Accident/Injury Yes ☐ No ☐
Date:
Type: Motor vehicle
Fall
Blow to Head
Industrial
Other

Medical/Surgical? ☐ Yes ☐ No
Date:
Type: Medication-related
Stroke
Aneurysm
Hemorrhage
Drug Abuse
Poison/Toxic Substance
Other

Was injury:
Open Head (bleeding) ☐ Yes ☐ No
Closed Head (non-bleeding) ☐ Yes ☐ No

What part of your head was affected?
(check all that apply)

☐ Forehead ☐ Right side
☐ Left side ☐ Back of Head
☐ Top of Head ☐ Face
☐ Brainstem

Did you lose consciousness? ☐ Yes ☐ No
If yes, how long?
Were you in a coma? ☐ Yes ☐ No
If yes, how long?

Medical History

Patient's Name_____Date_____

Please check any of the following which pertains: Last Medical Examination Date_____

Allergies/ Immunology
_____Drug Allergies
_____Environmental Allergy
_____Rheumatoid Arthritis
_____Lupus
_____Other
List all allergies:

Respiratory
_____Allergies
_____Cigarette Smoker
_____Asthma
_____Bronchitis
_____Other
Explain:

Psychiatric
_____Depression
_____Panic Disorder
_____Schizophrenia
_____Memory Loss
_____Other
Explain:

Integumentary
_____Eczema
_____Rosaces
_____Psoriasis
_____Ring Worm
_____Other
Explain:

Cardiovascular
_____Heart Disease
_____Hypertension
_____Stroke
_____Vascular Disease
_____Other
Explain:

Musculoskeletal
_____Fibromyalgia
_____Muscular Dystrophy
_____Osteoarthritis
_____Cold Extremities
_____Other
Explain:

Constitutional
_____General Good Health
_____Recent Weight Change
_____Fever
_____Fatigue
_____Developmental Disability
_____Other
Explain:

Neurological
_____Paralysis
_____Numbness or Tingling
_____Headaches
_____Light Headed or Dizzy
_____Convulsions/ Seizures
_____Tremors
_____Head Injuries
_____Other
Explain:

Eye/Ear/Nose
_____Tubes in Ears
_____Earaches or Drainage
_____Chronic Sinus Problems
_____Glaucoma
_____Cataracts
_____Eye Turn
_____Hearing Loss Injury
_____Other
Explain:

Hematological/ Lymphatic
_____Anemia
_____Bleeder
_____Slow to heal after cut
_____Leukemia
_____Large volume blood loss
_____Enlarged glands
_____Blood transfusions
_____Other
Explain:

Gastrointestinal
_____Loss of appetite
_____Bowel movement changes
_____Abdominal pain
_____Crohn's
_____Colitis
_____Ulcers
_____Other
Explain:

Endocrine
_____Non insulin dep. Diabetic
_____Insulin dep. Diabetic
_____Thyroid dysfunction
_____Hormonal dysfunction
_____Other
Explain:

This information is confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes, please describe:_____
Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long?_____
Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long?_____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Visual History

Previous eye examination:
Date:_____
Doctor's name:_____
Location:_____
Reason for examination:_____
_____
_____
Were glasses prescribed? ☐ Yes ☐ No
How are they worn?_____
Are contact lenses worn? ☐ Yes ☐ No
How are they worn?_____
When was the visual difficulty first noted?_____
_____
_____
Did the problem occur suddenly, related to accident or trauma? Explain:_____
_____
_____
_____
Have there been any treatments to remedy the problem such as:
Vision therapy_____
Patching_____
Eye surgery_____
Other_____
_____
Have you seen improvements with therapy?_____
_____
_____
_____
Other related information regarding vision:
_____
_____
_____
_____
_____

Motor Vehicle Accident

Type of vehicle you were in:_____
Other vehicle(s) involved:_____
Were you sitting in:
☐ Front Seat ☐ Back Seat ☐ Middle
☐ Left Side ☐ Right Side ☐ Unusual Position
Which restraints were used? (Check all that apply)
☐ Lap ☐ Shoulder ☐ Car Seat
☐ Booster Seat ☐ Air Bag
Speed of vehicle you were in:_____
Speed of other vehicle or object:_____
Did your vehicle hit another object? ☐ Yes ☐ No
Or did the other vehicle hit your vehicle? ☐ Yes ☐ No
If yes, where was your vehicle hit:
☐ Head on ☐ Toward front ☐ Drivers side
☐ Rear ended ☐ Toward rear ☐ Passenger side
Did you experience whiplash? ☐ Yes ☐ No
Did you hit your head? ☐ Yes ☐ No
If yes, on what?_____
_____
_____

Lifestyle

Do you feel your vision interferes with activities of daily living?
☐ Yes ☐ No
Explain:_____
_____
_____
What activities comprise the majority of your daily life since your accident/injury?
_____
_____
_____
What changes/limitations in your daily life do you attribute to your injury/surgery?
_____
_____
_____

Symptoms Immediately Following Head Trauma

Please check all that apply:

- ☐ Double vision
- ☐ Blurred vision
- ☐ Pain around eyes
- ☐ Flashes of light
- ☐ Floaters
- ☐ Blindness
- ☐ Turned eyes
- ☐ Restricted field of vision
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Disorientation
- ☐ Vomiting
- ☐ Neck pain
- ☐ Whiplash
- ☐ Loss of memory

Symptoms: Current

Yes	No	
☐	☐	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
☐	☐	Difficulty in stores or malls
☐	☐	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 is 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
☐	☐	Holds books too close
☐	☐	Avoids 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 past 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

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

_____

_____

_____

_____

_____

_____

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.

Patient's Name _____Date_____

COVD-Quality of Life Questionnaire

Check the column which best represents the occurrence of each symptom.

Completed by: _____

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Difficulty comprehending what is read					
Holds document/book too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Other comments: