Vision Therapy Centers, SC
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Neuro-Developmental
Optometrist

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Neuro History (4 to 21 years)

Date_____ Completed By_____
How did you learn about A B See?_____

General Information

Child's name
_____
(LAST) (FIRST) (M)
Birth Date_____ Age_____Grade ____ Gender F M
Home Address_____
City_____ State_____ Zip_____
Name of Health Care Plan_____
Policy Holder_____
Policy number_____Group#_____
Medical Billing Address_____
_____
Pediatrician_____
Pediatrician's phone number_____

Parent Information

Father's name
_____
(LAST) (FIRST) (M)
Home Address_____
City_____ State_____ Zip_____
Home phone___(____)_____
Cell phone____(____)_____
E-mail_____
Father's occupation_____
Employer_____
Work phone___(____)_____
May we contact you at your business? ☐ Yes ☐ No

Mother's Name
_____
(LAST) (FIRST) (M)
Home Address_____
City_____State_____ Zip_____
Home phone___(____)_____
Cell phone____(____)_____
E-mail_____
Mother's occupation_____
Employer_____
Work phone___(____)_____
May we contact you at your business? ☐ Yes ☐ No

Responsible Party_____
Phone_____(____)_____

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?
_____
_____
_____

School 1st - 12th Grade

Name of Current School:

School Address:

City_____ State_____ Zip_____
School Phone: (_____)_____
Teacher's Name:_____
Grade: _____
Has a grade been repeated? ☐Yes ☐No
Which one?_____
Has he/she changed schools often? ☐Yes ☐No
When?_____
Age at entrance to kindergarten:_____
Age at entrance to first grade:_____
Does child like school? ☐Yes ☐No
Does child like teacher? ☐Yes ☐No
Currently what are average grades overall:

A B C D F

School work/grades in the following classes are at which level? (please check)

	Above Average	Average	Below Average
Reading	_____	_____	_____
Math	_____	_____	_____
Spelling	_____	_____	_____
Writing	_____	_____	_____
Gym	_____	_____	_____

Do you feel he/she is working up to potential?

Does teacher feel he/she is working up to potential?

What school subjects come easy for child?

Does child like to read? ☐Yes ☐ No
Does child like to read voluntarily? ☐Yes ☐ No

Has he/she had any special tutoring and/or remedial assistance? ☐Yes ☐No
When?_____
From whom?_____
Where?_____
How long?_____
Results:_____

Does he/she seem to be under tension or extreme pressure when doing school work?_____

How well developed is his/her spoken vocabulary?

What is the child's attitude toward reading, school, his/her teacher, other youngsters?_____

Specifically describe any school difficulties:

College/Technical College

Major_____

Specifically describe any school difficulties:

General Behavior

Are there any behavior problems?
School:_____Home:_____
What causes these problems?

Child's reaction to fatigue:
Sad:_____Irritable:_____Other:_____
Child's reaction to tension: Nail biting:_____
Thumb sucking:_____Other:_____

Have you ever noticed the following:

☐Yes ☐No Says and/or does things impulsively?
☐Yes ☐No Is in constant motion?
☐Yes ☐No Can't sit still for long periods?
☐Yes ☐No Can't watch TV over 15 minutes?
☐Yes ☐No Speech difficult to understand?
☐Yes ☐No Stutters?
☐Yes ☐No Omits parts of word?
☐Yes ☐No Asks for frequent repetitions?
☐Yes ☐No Difficulty expressing thoughts?

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: