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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.

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 / Guardian Information

Parent 1 / Guardian's name

(LAST) (FIRST) (M)

Home Address _____

City _____ State _____ Zip _____

Home phone () _____

Cell phone () _____

E-mail _____

Parent's occupation _____

Employer _____

Work phone () _____

May we contact you at your business? Yes No

Parent 2 / Guardian's Name

(LAST) (FIRST) (M)

Home Address _____

City _____ State _____ Zip _____

Home phone () _____

Cell phone () _____

E-mail _____

Parent's occupation _____

Employer _____

Work phone () _____

May we contact you at your business? Yes No

Responsible Party _____

Phone () _____

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

- | | |
|---|---|
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Family Physician |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Neuropsychologist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Emergency Room Doctor |
| <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Audiologist/Otolaryngologist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Chiropractor | |
| <input type="checkbox"/> Other _____ | |

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

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? _____

Does child like to read voluntarily? Yes No

Has he/she had any special tutoring Yes No

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:

- | | |
|---|--|
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain around eyes | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Turned eyes | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Restricted field of vision | <input type="checkbox"/> Loss of memory |

Symptoms: Current

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes ache |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes pull or tug |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty moving or turning eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain with movement of eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes twitch |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in or around eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye redness |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Watery eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Brightness is bothersome |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in stores or malls |
| <input type="checkbox"/> | <input type="checkbox"/> | Motion sickness/car sickness |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty changing focus far to near |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision |
| <input type="checkbox"/> | <input type="checkbox"/> | One eye turns in, out, up or down |
| <input type="checkbox"/> | <input type="checkbox"/> | Movement of objects in the environment is bothersome |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluorescent light is bothersome |
| <input type="checkbox"/> | <input type="checkbox"/> | Patterned wallpaper or carpets is bothersome |
| <input type="checkbox"/> | <input type="checkbox"/> | Head moves when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Lose place often when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Words jump or move around when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Short attention span for reading or writing |

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Skip words frequently when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Discomfort when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of interest/concentration when doing close work |
| <input type="checkbox"/> | <input type="checkbox"/> | Orient writing/drawing poorly on page |
| <input type="checkbox"/> | <input type="checkbox"/> | Squinting, covering or closing one eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Head tilts during desk work |
| <input type="checkbox"/> | <input type="checkbox"/> | Holds books too close |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids reading or writing |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with peripheral vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects jump in and out of field of view |
| <input type="checkbox"/> | <input type="checkbox"/> | Reduced depth perception |
| <input type="checkbox"/> | <input type="checkbox"/> | Tunnel vision/loss of visual field |
| <input type="checkbox"/> | <input type="checkbox"/> | Flashes of light |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with bathing/personal hygiene |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty following a series of directions |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty using both sides of the body together |
| <input type="checkbox"/> | <input type="checkbox"/> | Dislike heights |
| <input type="checkbox"/> | <input type="checkbox"/> | Awkward, poor balance |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion/disorientation |
| <input type="checkbox"/> | <input type="checkbox"/> | Get lost often |
| <input type="checkbox"/> | <input type="checkbox"/> | Bothered by noises |
| <input type="checkbox"/> | <input type="checkbox"/> | Bothered by touch |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering things heard |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering things seen |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering name of objects |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering people's names |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty recalling past information known in the past |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering formerly familiar people/objects |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty performing tasks formerly easy/routine |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with time management |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with numbers |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____

COVID-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:

