

# The Center for Vision Development

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Thank you for carefully completing this questionnaire.

***Please return all forms at least 24 hours prior to your appointment by fax, email or regular mail.***

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age Now: \_\_\_\_\_ Gender: Male  Female

Were you referred to us? Yes  No

If you were referred, whom may we thank? \_\_\_\_\_

Referral Type: Doctor  Therapist  Tutor/Teacher  Family

Friend  Other: \_\_\_\_\_

If not referred, how did you hear about us? \_\_\_\_\_

## CONTACT INFORMATION

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_

Business Phone: \_\_\_\_\_

Preferred Method of Contact: Home Phone  Business Phone

Cell Phone  Email

Person to Contact in Case of Emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

# MEDICAL HISTORY

Medications (include vitamins/supplements): \_\_\_\_\_

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Are you allergic to any medications? Yes  No

If "Yes," please list: \_\_\_\_\_

Please indicate if you have problems with any of the below.

<b>Event/Condition</b>	<b>Yes/No</b>	<b>Please describe, including time of onset</b>
Constitutional symptoms (e.g. fever, weight loss)		
Hematologic (e.g. anemia)		
Allergic/immunologic		
Endocrine		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
Ears, nose, mouth or throat		
Gastrointestinal		
Skin disorders		
Musculoskeletal		
Genitourinary		

# TRAUMA HISTORY

Date of accident/trauma: \_\_\_\_\_

Describe the accident/trauma: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please select the type of accident/trauma from the list below:**

**Motor Vehicle**

Type of vehicle you were in: \_\_\_\_\_

If other vehicle(s) involved, list type(s): \_\_\_\_\_

Where were you sitting?

Front Seat

Left Side

Middle

Back Seat

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 object or vehicle: \_\_\_\_\_

Did your vehicle hit another object? Yes  No

Did another 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? \_\_\_\_\_

**Other Accidents**

Type (ex: home/industrial fall, hit by object, etc.): \_\_\_\_\_

Please describe: \_\_\_\_\_

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**Toxic**

Type (ex: medication related, drug abuse, poison, etc.): \_\_\_\_\_

Please describe: \_\_\_\_\_

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**Anoxic**

Type (ex: drowning, CO2, anesthesia, cord around neck, etc.): \_\_\_\_\_

Please describe: \_\_\_\_\_

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**Vascular**

Type (ex: stroke, aneurysm, hemorrhage, etc.): \_\_\_\_\_

Please describe: \_\_\_\_\_

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**Other**

Type: \_\_\_\_\_

Please describe: \_\_\_\_\_

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## Head Injury Description

What part of your head was affected?

Forehead

Right Side

Top of head

Back of Head

Left Side

Face

Were you unconscious? Yes  No  If so, for how long? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Initial Care

Did you see a doctor concerning the accident? Yes  No

Whom did you see? \_\_\_\_\_

When? \_\_\_\_\_

Where? \_\_\_\_\_

What were you or your family told? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Subsequent/Other Professional Care

What kind of professional care for your injuries/trauma have you received or are you receiving?

Family Physician: \_\_\_\_\_

Chiropractor: \_\_\_\_\_

Neurologist: \_\_\_\_\_

Neuropsychologist: \_\_\_\_\_  
Emergency Room Doctor: \_\_\_\_\_  
Occupational Therapist: \_\_\_\_\_  
Physical Therapist: \_\_\_\_\_  
Speech Therapist: \_\_\_\_\_  
Audiologist/Otolaryngologist: \_\_\_\_\_  
Psychologist: \_\_\_\_\_  
Physiatrist: \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_  
Optometrist: \_\_\_\_\_  
Ophthalmologist: \_\_\_\_\_  
Osteopath: \_\_\_\_\_  
Massage Therapist: \_\_\_\_\_  
Other: \_\_\_\_\_

**Symptoms immediately following the accident**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Double Vision  | <input type="checkbox"/> Headache                  | <input type="checkbox"/> Loss of Memory    |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Pain In or Around Eyes    | <input type="checkbox"/> Vomiting          |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Restrictive Field of View | <input type="checkbox"/> Loss of Balance   |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Flashes of Light          | <input type="checkbox"/> Restricted Motion |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What types of difficulties did you experience following the accident/trauma?**

**Work Related**

Please describe:

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**Hobbies/Avocational**

Please describe:

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**Recreational/Social**

Please describe:

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## Subsequent Symptoms/Experiences

Please consider each symptom and place "X" in all the columns that apply.

Place check under MIN if the symptom is only minimally present or MAX if the symptom is very significant.

Symptom	Was present before accident		Had before accident and has worsened		New symptom since accident	
	MIN	MAX	MIN	MAX	MIN	MAX
Blurred vision, distance viewing .....	___	___	___	___	___	___
Blurred vision, near viewing.....	___	___	___	___	___	___
Slow to shift focus, near to far to near.....	___	___	___	___	___	___
Difficulty taking notes.....	___	___	___	___	___	___
Pulling or tugging sensation around eyes	___	___	___	___	___	___
Difficulty moving or turning eyes.....	___	___	___	___	___	___
Pain with movement of the eyes.....	___	___	___	___	___	___
Wandering eye.....	___	___	___	___	___	___
Double vision.....	___	___	___	___	___	___
Loss of place while reading.....	___	___	___	___	___	___
Discomfort while reading.....	___	___	___	___	___	___
Unable to sustain near work/reading for adequate periods.....	___	___	___	___	___	___
General fatigue while reading.....	___	___	___	___	___	___
Eyes get tired while reading.....	___	___	___	___	___	___
Headaches .....	___	___	___	___	___	___
Pain in or around eyes.....	___	___	___	___	___	___
Easily distracted.....	___	___	___	___	___	___
Decreased attention span.....	___	___	___	___	___	___
Reduced concentration ability.....	___	___	___	___	___	___
Difficulty remembering what has been read.....	___	___	___	___	___	___

Please consider each symptom and place "X" in all the columns that apply.

Place check under MIN if the symptom is only minimally present or MAX if the symptom is very significant.

Symptom	Was present before accident		Had before accident and has worsened		New symptom since accident	
	MIN	MAX	MIN	MAX	MIN	MAX
Difficulty remembering things heard.....	___	___	___	___	___	___
Difficulty remembering things seen.....	___	___	___	___	___	___
Dizziness.....	___	___	___	___	___	___
Poor coordination.....	___	___	___	___	___	___
Clumsiness.....	___	___	___	___	___	___
Loss of balance.....	___	___	___	___	___	___
Poor eye-hand coordination.....	___	___	___	___	___	___
Poor handwriting.....	___	___	___	___	___	___
Poor posture.....	___	___	___	___	___	___
Head tilt.....	___	___	___	___	___	___
Face turn.....	___	___	___	___	___	___
Covering, closing one eye.....	___	___	___	___	___	___
Disorientation.....	___	___	___	___	___	___
Get lost often.....	___	___	___	___	___	___
Bothered by movement around you.....	___	___	___	___	___	___
Bothered by noises around you.....	___	___	___	___	___	___
Bothered by being touched.....	___	___	___	___	___	___
Abnormal general fatigue.....	___	___	___	___	___	___
Reduced depth perception.....	___	___	___	___	___	___
Light sensitivity.....	___	___	___	___	___	___
Flashes of light.....	___	___	___	___	___	___
Floaters in field of view.....	___	___	___	___	___	___
Restricted field of vision.....	___	___	___	___	___	___
Tunnel vision.....	___	___	___	___	___	___
"Curtain" billowing into field of view.....	___	___	___	___	___	___

If you have any questions or concerns that we may answer prior to your appointment, please contact us.

# Release of Information

**IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE, *WITH YOUR PERMISSION*. 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 the The Center for Vision Development when it is necessary for the treatment of my visual condition. I authorize Dr. Christina Danley and The Center for Vision Development to exchange information with other professionals involved in my care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name