Comprehensive Vision Therapy Center
5300 California Ave., Ste. 210
Bakersfield, CA 93309

VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully prior to your appointment time. THANK YOU.

We understand that it is long, but it will help us provide the best care for your vision needs.

Person assisting the patient with this form:____________________Relation: ____________
Appointment: Day ____________________ Date ____________ Time _________________
Were you referred to our office? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _________________ Phone: ___________

GENERAL INFORMATION

Patient Name:____ ☐ Male ☐ Female
Birth Date:__________________________ Age:________ email:___________________________
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Home Address: ____
Home Phone: ____________________________________ Work Phone: ____________________
Social Security Number: _______________________________ Driver's License No.: ___________
Insurance Company: _______________________________________ Subscriber:_______________
ID# ___ Group #: _________________ Subscriber's Birth Date ______________________________
What is your occupation? _______________________________ Employer: ___________________
Employer at time of Workers Comp injury: ____________________Occupation:_______________
Business Address: ____
Spouse's Name: ____________________________________ Occupation: __________________
Spouse's Employer: _________________________________ Phone #: _____________________
Business Address: ____
Responsible Party: ____

MEDICAL HISTORY

Please list all medications or supplements you are currently taking:________________________
____
____
Allergies to Medications:____
Other Allergies:____
List all other major injuries, surgeries and/or hospitalizations you have had:________.________
____

FAMILY HISTORY

Please note any family history for the following conditions:

Blindness ……………… ☐Yes ☐ No
Cataract………………… ☐Yes ☐ No
Crossed Eyes…………… ☐Yes ☐ No
Glaucoma………………. ☐Yes ☐ No
Macular Degeneration….. ☐Yes ☐ No
Retinal Detachment…….. ☐Yes ☐ No
Thyroid Disease……….... ☐Yes ☐ No

Cancer………………. ☐Yes ☐ No
Diabetes…………….. ☐Yes ☐ No
Heart Disease……….. ☐Yes ☐ No
High Blood Pressure... ☐Yes ☐ No
Kidney Disease……... ☐Yes ☐ No
Other_________________________

SOCIAL HISTORY

Do you drive currently? ☐Yes ☐ No, Did you drive before your injury? ☐Yes ☐ No
Do you use tobacco products? ☐Yes ☐ No Type/amount/how long? ____________________
Did you use tobacco products before your injury? ☐Yes ☐ No
Type/amount/how long? ____
Do you drink alcohol? ☐Yes ☐ No How much/how often?___________________________
Do you use illegal drugs? ☐Yes ☐ No ...type/how often?____________________________

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REVIEW OF SYSTEMS

VISION/EYES Do you, or have you ever had any problems in the following areas? **Circle, or explain.**

Blurred vision, Loss of vision, Flashes/floaters, Distorted vision/halos, Blind spots, Double vision, Discharge, Burning, Tearing, Itching, Eye pain, Dryness, Redness, Foreign body sensation, Light sensitivity, Chronic eyelid infection, Styes, NONE

____

Cardiovascular/Vascular:		Onset	**Immune system/Infections:**		Onset
High Blood Pressure	Y N	___________	Sjogrens syndrome	Y N	___________
Heart Probl.: ______________	Y N	___________	Autoimmune disease	Y N	___________
Vascular Disease	Y N	___________	HIV Positive/AIDS	Y N	___________
Other: ____________________	Y N	___________	Lyme disease	Y N	___________
Constitutional:			Sarcoidosis	Y N	___________
Fever	Y N	___________	Tuberculosis	Y N	___________
Weight gain/loss	Y N	___________	Other: ______________________	Y N	___________
Fatigue:	Y N	___________	**Integumentary/Skin:**		
Other: ____________________	Y N	___________	Skin rash/hives	Y N	___________
Endocrine:			Dermatitis	Y N	___________
Diabetes	Y N	___________	Dry skin	Y N	___________
Thyroid	Y N	___________	Other: ______________________	Y N	___________
Pituitary disorder	Y N	___________	**Musculoskeletal:**		
Other:_____________________	Y N	___________	Arthritis	Y N	___________
Gastrointestinal:			Muscle pain	Y N	___________
Diarrhea	Y N	___________	Skeletal Disorder	Y N	___________
Constipation	Y N	___________	Other: ______________________	Y N	___________
Other:_____________________	Y N	___________	**Neurological:**		
Genitourinary:			Headache/Migraine	Y N	___________
Genital	Y N	___________	Brain tumor	Y N	___________
Kidney	Y N	___________	Seizures	Y N	___________
Bladder	Y N	___________	Stroke	Y N	___________
Other: ____________________	Y N	___________	Other: ______________________	Y N	___________
Ears/Nose/Mouth/Throat:			**Psychiatric:** (Please describe)	Y N	
Runny nose	Y N	___________	___________________________	Y N	___________
Chronic cough	Y N	___________	___________________________	Y N	___________
Dry throat/mouth	Y N	___________	**Respiratory:**		
Hearing loss	Y N	___________	Asthma	Y N	___________
Sinus disease	Y N	___________	Emphysema	Y N	___________
Other: ____________________	Y N	___________	Chronic bronchitis	Y N	___________
Hematologic/Lymphatic			Other: ___________________	Y N	___________
Anemia	Y N	___________			
Blood disorder	Y N	___________			
Bleeding problem	Y N	___________			
Other: ____________________	Y N	___________			

Date of onset of Neurologic difficulty.____

Any other health or developmental issues, Please Explain:____________________________

____

____

Any history of prior injuries, including head other than one we may be examining you for today, Please Explain:____

____

____

____

____

HISTORY OF CURRENT INJURY

Please complete this section (a) if there was an incident or multiple incidents that resulted in the neurological impairment and (b) you do not have copies of reports that explain the detailed history of the injury.

OTHERWISE, skip to: SUBSEQUENT/OTHER PROFESSIONAL CARE

Date of injury/accident:____

Brief description of injury:____

____

Was the injury OPEN HEAD (skull fracture) or CLOSED HEAD (no skull fracture)? (please circle one)

Did you lose consciousness? ☐Yes ☐ No If yes, for how long? _______________

Were you in a coma? ☐Yes ☐ No If yes, for how long? _______________

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

☐ Double vision ☐ Blurred vision ☐ Flashes of light ☐ Pain in or around eyes

☐ Headache ☐ Memory loss ☐ Disorientation ☐ Restricted field of view

☐ Vomiting ☐ Dizziness ☐ Loss of balance ☐ Neck pain/whiplash

Other: ____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? ________________________

Name of Doctor: ____Specialty: ____________

Were you hospitalized? ☐ Yes ☐ No How long? ____________

What were your diagnoses?____

____

What prognosis/recommendations were you given? ______________________________________

____

SUBSEQUENT/OTHER PROFESSIONAL CARE

Has a neurological evaluation been performed? ☐Yes ☐ No

If yes, by whom? ________________________ Date: ______________________________

Recommendations: ____

Has a psychological evaluation been performed? ☐Yes ☐ No

If yes, by whom? ________________________ Date: ______________________________

Recommendations: ____

Has a vision/eye evaluation been performed? ☐Yes ☐ No

If yes, by whom? ____Date: ____________

Recommendations: ____

PLEASE LIST any other professionals that have evaluated or are currently working with you such as a: Physician, Physiatrist, Neurologist, Neuropsychologist, Psychologist / Psychiatrist, Physical Therapist, Speech/Language Therapist, Occupational Therapist, Osteopathic Physician, Tutor or others, Please list:

Name	Profession	Recommendations	Date(s)

LIFESTYLE

Do you feel your vision interferes with activities of daily living? ☐ Yes ☐ No

If yes, please explain (please include effects involving home, work, hobbies, social, and personal relationships): ____________________

What activities comprise the majority of your daily life since your accident/injury?____________________

What activities can you no longer engage in due to your visual or other difficulties? ____________________

What other changes/limitations in your daily life do you attribute to your accident/injury? ____________________

What do you hope a Visual Rehabilitation Program can do for you? ____________________

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What was your employment position prior to your injury?____________________
What is current employment position? ____________________
What is the highest grade you completed in school?____________________
How were your grades?____________________
If a student, what is the major course of study? ____________________
How many hours daily are spent working at near distance? ____________________
How many hours daily are spent reading/studying? ____________________
How many hours daily are spent with a computer? ____________________

Please rate each behavior since your illness or injury. How often does each behavior occur? (circle a number)	After Injury: Never	Seldom	Occasional	Frequently	Always		Prior to Injury: Never	Seldom	Occasional	Frequently	Always
EYESIGHT CLARITY											
Distance vision blurred and not clear—even with lenses.	0	1	2	3	4		0	1	2	3	4
Near vision blurred and not clear—even with lenses.	0	1	2	3	4		0	1	2	3	4
Clarity of vision changes or fluctuates during the day.	0	1	2	3	4		0	1	2	3	4
Poor night vision/can't see well to drive at night.	0	1	2	3	4		0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4		0	1	2	3	4
VISUAL COMFORT											
Eye discomfort/sore eyes/eyestrain.	0	1	2	3	4		0	1	2	3	4
Pain in or around eyes.	0	1	2	3	4		0	1	2	3	4
Headaches .	0	1	2	3	4		0	1	2	3	4
Eye fatigue/very tired after using eyes all day.	0	1	2	3	4		0	1	2	3	4
Feel "pulling" around the eyes.	0	1	2	3	4		0	1	2	3	4
Motion sickness/car sickness.	0	1	2	3	4		0	1	2	3	4
DOUBLING											
Double vision—especially when tired.	0	1	2	3	4		0	1	2	3	4
Have to close or cover one eye to see clearly.	0	1	2	3	4		0	1	2	3	4
LIGHT SENSITIVITY											
Normal indoor lighting is uncomfortable—too much glare.	0	1	2	3	4		0	1	2	3	4
Outdoor light too bright—have to use sunglasses.	0	1	2	3	4		0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying.	0	1	2	3	4		0	1	2	3	4
OCULAR HEALTH											
Eyes feel "dry" and sting.	0	1	2	3	4		0	1	2	3	4
Eyes Water.	0	1	2	3	4		0	1	2	3	4
Have to rub the eyes a lot.	0	1	2	3	4		0	1	2	3	4
Flashes of Light.	0	1	2	3	4		0	1	2	3	4
DEPTH PERCEPTION											
Clumsiness /misjudge where objects really are.	0	1	2	3	4		0	1	2	3	4
Reduced depth perception.	0	1	2	3	4		0	1	2	3	4
Lack of confidence walking/missing steps/stumbling.	0	1	2	3	4		0	1	2	3	4
Poor handwriting (spacing, size, legibility).	0	1	2	3	4		0	1	2	3	4
SPATIAL VISION											
Side vision distorted/objects move or change position.	0	1	2	3	4		0	1	2	3	4
What looks straight ahead—isn't always straight ahead.	0	1	2	3	4		0	1	2	3	4
Avoid crowds/can't tolerate "visually-busy" places.	0	1	2	3	4		0	1	2	3	4

	After Injury						Prior to Injury				
Please rate each behavior since your illness or injury. How often does each behavior occur? (circle a number)	Never	Seldom	Occasional	Frequently	Always		Never	Seldom	Occasional	Frequently	Always
Patterned wallpaper or carpet are bothersome.	0	1	2	3	4		0	1	2	3	4
Awkward, poor balance.	0	1	2	3	4		0	1	2	3	4
Dizziness.	0	1	2	3	4		0	1	2	3	4
Confusion / disorientation.	0	1	2	3	4		0	1	2	3	4
Get lost often.	0	1	2	3	4		0	1	2	3	4
READING											
Short attention span/easily distracted when reading.	0	1	2	3	4		0	1	2	3	4
Difficulty/slowness with reading and writing.	0	1	2	3	4		0	1	2	3	4
Words jump or move around when reading.	0	1	2	3	4		0	1	2	3	4
Discomfort/fatigue when reading.	0	1	2	3	4		0	1	2	3	4
Poor reading comprehension/can't remember what was read.	0	1	2	3	4		0	1	2	3	4
Confusion of words.	0	1	2	3	4		0	1	2	3	4
Skip words during reading.	0	1	2	3	4		0	1	2	3	4
Lose place/have to use finger not to lose place when reading.	0	1	2	3	4		0	1	2	3	4
PERIPERAL VISION											
Difficulty with peripheral vision.	0	1	2	3	4		0	1	2	3	4
MEMORY											
Difficulty remembering things heard.	0	1	2	3	4		0	1	2	3	4
Difficulty remembering things seen.	0	1	2	3	4		0	1	2	3	4
Difficulty remembering name of objects.	0	1	2	3	4		0	1	2	3	4
Difficulty remembering people's names.	0	1	2	3	4		0	1	2	3	4
Difficulty recalling recent information.	0	1	2	3	4		0	1	2	3	4
Difficulty remembering formerly familiar people / objects.	0	1	2	3	4		0	1	2	3	4
GENERAL/ADLs											
Difficulty with time management.	0	1	2	3	4		0	1	2	3	4
Difficulty with numbers.	0	1	2	3	4		0	1	2	3	4
Bothered by touch.	0	1	2	3	4		0	1	2	3	4
Difficulty counting money.	0	1	2	3	4		0	1	2	3	4
Difficulty dressing/bathing/personal hygiene.	0	1	2	3	4		0	1	2	3	4
"Stare" into space without blinking.	0	1	2	3	4		0	1	2	3	4

Release of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Drs. Penelope Suter or any doctors under her employ when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

____ ____________________

Signature of patient or authorized representative Date

It is often beneficial for us to discuss examination results and to exchange information with family members and/or care givers involved in your care. Please list any person with whom we may exchange information and sign below to authorize this exchange of information.

Name:___________________________________Relationship:_______________________

Name:___________________________________Relationship:_______________________

Name:___________________________________Relationship:_______________________

I authorize the release of medical information to the persons listed above. This authorization shall be considered valid for the duration of my treatment.

____ ____________________

Signature of patient or authorized representative Date

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.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

(Person who is filling this form out, please sign below. If you are not the patient please indicate as such.)

Signed:______________________ Print Name:____________________Relation: ________________

Date:________________________