

# Alderwood

## Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a comprehensive vision examination. On the following pages you will find a Returning Adult Vision Questionnaire and symptom checklist. **Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the examination.**

Thank you again for your cooperation in providing this complete history.  
We look forward to seeing you!

16006 Ash Way, Suite 101, Lynnwood, WA 98087  
Phone: (425) 787-5200 Fax: (425) 787-5252

---

Nancy G. Torgerson  
Doctor of Optometry

Kristi A. Jensen  
Doctor of Optometry

Willow F. Thompson  
Doctor of Optometry

# DRIVING DIRECTIONS

Alderwood Vision Therapy Center, PLLC  
16006 Ash Way, Suite #101  
Lynnwood, WA 98087  
(425) 787-5200

---

---

---

## **Southbound on I-5 coming from Everett, WA**

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **Northbound on I-5 coming from Seattle, WA**

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **Northbound on I-405**

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **From the Edmonds Ferry:**

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

**Our office is located in a separate building at the north end of Newberry Square.**

## RETURNING ADULT VISION QUESTIONNAIRE

*Please fill out this questionnaire carefully.*

*Please return it to our office prior to your appointment. **THANK YOU.***

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Patient's Name: \_\_\_\_\_

### GENERAL INFORMATION

Were you referred to our office? Yes  No

If yes, whom may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_  
Address \_\_\_\_\_ Profession: \_\_\_\_\_

Patient's Full Legal Name: \_\_\_\_\_ Male  Female

Patient's Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

Email: \_\_\_\_\_ Marital status: Single  Married  Divorced  Widowed

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE

Do you have Vision Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group#: \_\_\_\_\_

Do you have Medical Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group#: \_\_\_\_\_

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S)  
WITH YOU TO YOUR APPOINTMENT.**

**Vision Health History**

Reason for today's visit: \_\_\_\_\_

Last Vision examination: \_\_\_\_\_ Results: \_\_\_\_\_

Do you wear glasses? Yes  No  For: constant wear occasional wear near far

Do you wear contact lenses? Yes\*  No  For: full time wear occasional wear

*\* For Your Information: We refer out for contact lens fitting, dispensing and follow-up.*

Type: Soft Rigid Gas Permeable

Visual demands: At work (reading, computer, etc.) \_\_\_\_\_

At play (sports/hobbies) \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

For what condition: \_\_\_\_\_

General health: Good \_\_\_\_\_ Poor \_\_\_\_\_

History of eye surgery/LASIK: Yes or No Explain: \_\_\_\_\_

Allergies: Yes  No  Specify: \_\_\_\_\_

**Social History:**

Do you smoke? Yes  No  What do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you drink? Yes  No  What do you drink? \_\_\_\_\_ How much per day? \_\_\_\_\_

Do you use recreational drugs? Yes  No  What Drug? \_\_\_\_\_ How often: \_\_\_\_\_

List patient's special needs (autistim/developmental delays, etc): \_\_\_\_\_

List any special concerns: \_\_\_\_\_

**Have you or a family member been treated for any condition related to:**

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematological/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			

**Specifically is there any family history of:**

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia(lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double-vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus(eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

**DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:**

Yes

- 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
- Dry eyes
- Brightness is bothersome
- Motion sickness / car sickness
- Headaches
- Blurred vision at distance
- Blurred vision at near
- Tunnel vision / Loss of visual field
- Flashes of light
- Dizziness
- Double vision
- Frequent Sties
  
- Head moves when reading
- Lose place often when reading
- Avoid reading or writing
- Words jump or move around when reading
- Short attention span for reading or writing
- Skip words frequently when reading
- One eye turns in, out, up or down
- Movement of objects in the environment is bothersome
- Flourescent light is bothersome
- Patterned wallpaper or carpets are bothersome
- Objects jump in and out of field of view
- Reduced depth perception
- 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
- Comprehension decreases the longer you read
- Feels sleepy with reading
- Rubs eyes frequently after/while reading/on computer
- Trouble with spelling
- Often have to re-read a line just read
- Difficulty remembering what is read
- Turns head a great deal with reading or on computer
- Close or cover an eye (right or left)

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

- Often reverses letters, words, or numbers
- Dislike tasks requiring sustained visual attention
- Feel nervous, irritable, restless, or frustrated after sustained visual concentration
- Lose awareness of surroundings when concentrating
- Blink a lot
- Difficulty using binoculars
  
- Hold books too close
- Difficulty changing focus far to near
- Discomfort when reading
- Eyes tire quickly when reading, sewing, or on computer
- Distance blurs when looking up from close work
- Vision blurs when concentrating
  
- Restless when doing desk work
- Eye/body coordination activities (ie dancing) are difficult
- Tailgate when driving
- Eye/hand coordination sports (ie. tennis, baseball) are difficult
- Trouble judging distance when parking/pulling into traffic
- Frequently trip or stumble
- Feel uncomfortable in crowded area with a lot of movement

**FINANCIAL POLICY**

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide a receipt for reimbursement submission. Copayment is also required at the time of service.

**We are participating providers with:**

Blue Cross Blue Shield, Regence Blue Shield, Premera Blue Cross, Medicare, and Medicaid/DSHS (**only** open coupon and Regence Healthy Options) **We are not providers with any HMO.**

By signing below you authorize the release of any medical information to process your insurance claim or for the referral to another doctor. You also allow your payment from insurance to be sent directly to Alderwood Vision Therapy Center, PLLC.

**Please sign that you understand the above:**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_