

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 "Vision Rehabilitation Questionnaire". **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

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Doctor of Optometry

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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.

VISION REHABILITATION 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: _____

Marital status: Single Married Divorced Widowed

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone #: _____

Business Address: _____

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.**

MEDICAL HISTORY

Date of injury/accident: _____

Type of injury/accident:

- Motor vehicle Medication-related Cord around neck Stroke
- Fall Drug abuse Industrial Accident Aneurysm
- Blow to head Poison/toxic substance Carbon dioxide Hemorrhage
- Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead Right side Left side Back of head Top of head Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

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

Were you in a coma? Yes No If yes, how long? _____

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

- Double vision Vomiting Flashes of light Neck pain/whiplash
- Headache Restricted motion Disorientation Loss of memory
- Blurred vision Pain in/around eyes Loss of balance Restricted field of view
- Dizziness Other: _____

INITIAL TREATMENT

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

Name of Doctor: _____ Specialty: _____

Where were you seen? _____

Were you hospitalized? Yes No How long? _____

What were you and your family told? _____

What did the initial treatments consist of? _____

What prognosis/recommendations were you given? _____

Were you given medications? Yes No Medication: _____

For what condition(s)? _____

List any medications, including vitamins and supplements used at the current time: _____

Do you have any allergies to medications? _____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

- Physicians Name: _____ Date: _____
Results and recommendations: _____
- Psychiatrist Name: _____ Date: _____
Results and recommendations: _____
- Neurologist Name: _____ Date: _____
Results and recommendations: _____
- Neuropsychologist Name: _____ Date: _____
Results and recommendations: _____
- Osteopathic Physician's Name: _____ Date: _____
Results and recommendations: _____
- Physical Therapist Name: _____ Date: _____
Results and recommendations: _____

Occupational Therapist Name: _____ Date: _____
 Results and recommendations: _____

Speech / Language Therapist Name: _____ Date: _____
 Results and recommendations: _____

Psychologist / Psychiatrist Name: _____ Date: _____
 Results and recommendations: _____

Other / Name: _____ Date: _____
 Results and recommendations: _____

Why do you feel the need for a vision evaluation today? _____

Do you have a history of allergies? Yes No
 If yes, please explain: _____

Has a neurological evaluation been performed? Yes No
 If yes, by whom? _____ Date: _____
 Results: _____

Has a psychological evaluation been performed? Yes No
 If yes, by whom? _____ Date: _____
 Results: _____

Has a speech and language evaluation been performed? Yes No
 If yes, by whom? _____ Date: _____
 Results: _____

MEDICAL HISTORY

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

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</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: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Specifically, is there any history of the following: (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>	_____

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? _____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

Were glasses, contact lenses or other optical devices recommended? Yes No

If yes, what? _____

Are they used? Yes No If yes, when? _____

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes No

If yes, what? _____

Did you undergo these treatments? Yes No Explain: _____

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>Prior to Injury</u>
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"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Brightness is bothersome	<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 at distance	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision at near	<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"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<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"/>
Avoid reading or writing	<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	<input type="checkbox"/>	<input type="checkbox"/>
Skip words frequently when reading	<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 are bothersome	<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"/>
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"/>
Hold books too close	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty changing focus far to near	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with peripheral vision	<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"/>
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 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	<input type="checkbox"/>	<input type="checkbox"/>

LIFESTYLE

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

Is this new since the accident/injury? 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? _____

What goals have you set up that you would like us to help you meet? What are your short term and long term goals? _____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? _____
If a student, what is the major course of study? _____
How many hours daily are spent at a desk? _____
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? _____

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:** _____