VISION THERAPY EVALUATION

PATIENT NAME _____ **DATE OF BIRTH** ____ /____ /_____

PERSON ACCOMPANYING PATIENT _____

CONTACT PHONE (_____) _____ - _____ **EMAIL** _____

PLEASE CONTACT US VIA: ◯ PHONE ◯ TEXT ◯ EMAIL

HOW DID YOU HEAR ABOUT US? ◯ CURRENT PATIENT ◯ REFERRAL ◯ INTERNET SEARCH ◯ DRIVE BY ◯ OTHER

MEDICAL HISTORY

Please list/describe the type(s) of injury sustained and date(s) of occurrence:

_____

_____

_____

Please list any tests performed (ie. MRI, CT, etc.), date, and results: _____

_____

_____

Primary Care Physician: _____ Date of Last Evaluation: _____

Results / recommendations: _____

Date of Next Evaluation: _____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

_____

Are you *currently* undergoing any therapies/treatments? If *YES*, please describe.

_____

_____

_____

_____

Please indicate if you have seen any of the following professionals in relation to your injury:

Neurologist	By whom/when? _____
Psychologist	By whom/when? _____
Ophthalmologist	By whom/when? _____
Occupational Therapist	By whom/when? _____
Physical Therapist	By whom/when? _____
Speech Therapist	By whom/when? _____
Chiropractor	By whom/when? _____
Other	By whom/when? _____

Do you feel you may need a referral for one of the above-listed professionals? If *YES*, please explain. _____

_____

_____

_____

EYE/VISUAL HISTORY

Do you feel your vision has been affected since your injury? ○ YES ○ NO

If *YES*, how so? _____

_____

Has your vision been evaluated since your injury? ○ YES ○ NO

Date of last eye exam: _____

Doctor's name: _____ Doctor's phone: _____

Results/ recommendations: _____

Please indicated if you have been diagnosed with any of the following conditions:

Glaucoma	○ YES	○ NO	Strabismus (Eye Turn)	○ YES	○ NO
Macular Degeneration	○ YES	○ NO	Amblyopia (Lazy Eye)	○ YES	○ NO
Cataracts	○ YES	○ NO	Blindness/ Vision Loss	○ YES	○ NO
Dry Eye	○ YES	○ NO	Stroke	○ YES	○ NO
Diabetic Retinopathy	○ YES	○ NO	Migraines	○ YES	○ NO
Retinal Detachment	○ YES	○ NO	Color Blindness	○ YES	○ NO

SYMPTOM HISTORY

Please indicate if you are experiencing any of the following symptoms:

Double vision	☐ YES	☐ NO
Blurred vision	☐ YES	☐ NO
Light sensitivity	☐ YES	☐ NO
Loss of peripheral vision	☐ YES	☐ NO
Unable to find objects right in front of you	☐ YES	☐ NO
Motion sickness	☐ YES	☐ NO
Movement of objects are bothersome	☐ YES	☐ NO
Loss of place or skipping words when reading	☐ YES	☐ NO
Use of finger to keep place when reading	☐ YES	☐ NO
Short attention span for near work	☐ YES	☐ NO
Difficulty writing	☐ YES	☐ NO
One eye turns in or out	☐ YES	☐ NO
Covering or closing one eye	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Eye fatigue	☐ YES	☐ NO
Difficulty following a series of directions	☐ YES	☐ NO
Poor balance	☐ YES	☐ NO
Holds on to wall or person to walk	☐ YES	☐ NO
Difficulty using both sides of body together	☐ YES	☐ NO

Thank you for carefully completing this questionnaire. The information supplied will allow us to perform a more comprehensive evaluation to better meet your specific visual and/or medical needs.

Sincerely,

Susan A. Carter, O.D.
2053 Thunderhead Rd
Knoxville, TN 37922
www.nseyecare.com

RELEASE OF INFORMATION

It is often beneficial to discuss examination results/recommendations and to exchange information with other professionals involved in your care. 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 or insurance carriers upon their written request or the recommendation of Dr. Susan when it is necessary. I authorize Dr. Susan Carter and Northshore Specialty Eyecare 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