

CONCUSSION EVALUATION

PATIENT NAME _____ DATE OF BIRTH ____/____/____

PERSON ACCOMPANYING PATIENT _____

CONTACT PHONE (____) _____ - _____ EMAIL _____

- PLEASE CONTACT US VIA: PHONE TEXT EMAIL
 CURRENT PATIENT REFERRAL
HOW DID YOU HEAR ABOUT US? 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	<input type="radio"/> YES	<input type="radio"/> NO	Strabismus (Eye Turn)	<input type="radio"/> YES	<input type="radio"/> NO
Macular Degeneration	<input type="radio"/> YES	<input type="radio"/> NO	Amblyopia (Lazy Eye)	<input type="radio"/> YES	<input type="radio"/> NO
Cataracts	<input type="radio"/> YES	<input type="radio"/> NO	Blindness/ Vision Loss	<input type="radio"/> YES	<input type="radio"/> NO
Dry Eye	<input type="radio"/> YES	<input type="radio"/> NO	Stroke	<input type="radio"/> YES	<input type="radio"/> NO
Diabetic Retinopathy	<input type="radio"/> YES	<input type="radio"/> NO	Migraines	<input type="radio"/> YES	<input type="radio"/> NO
Retinal Detachment	<input type="radio"/> YES	<input type="radio"/> NO	Color Blindness	<input type="radio"/> YES	<input type="radio"/> NO

SYMPTOM HISTORY

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

Headache	<input type="radio"/> YES	<input type="radio"/> NO
Blurred vision	<input type="radio"/> YES	<input type="radio"/> NO
Double Vision	<input type="radio"/> YES	<input type="radio"/> NO
Sensitivity to light	<input type="radio"/> YES	<input type="radio"/> NO
Dizziness	<input type="radio"/> YES	<input type="radio"/> NO
Motion sickness	<input type="radio"/> YES	<input type="radio"/> NO
Movement of objects are bothersome	<input type="radio"/> YES	<input type="radio"/> NO
Loss of place or skipping words when reading	<input type="radio"/> YES	<input type="radio"/> NO
Reduced reading comprehension	<input type="radio"/> YES	<input type="radio"/> NO
Reduced attention span for near work	<input type="radio"/> YES	<input type="radio"/> NO
Emotional changes/ irritability	<input type="radio"/> YES	<input type="radio"/> NO
Nausea/ vomiting	<input type="radio"/> YES	<input type="radio"/> NO
Covering or closing one eye	<input type="radio"/> YES	<input type="radio"/> NO
Difficulty riding in the car or driving	<input type="radio"/> YES	<input type="radio"/> NO
Eye fatigue	<input type="radio"/> YES	<input type="radio"/> NO
Problems with memory/ confusion	<input type="radio"/> YES	<input type="radio"/> NO
Poor balance	<input type="radio"/> YES	<input type="radio"/> NO
Sleep disturbances	<input type="radio"/> YES	<input type="radio"/> NO
Difficulty with eye-hand coordination	<input type="radio"/> YES	<input type="radio"/> 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 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