Arizona Vision Therapy Center

2312 N Rosemont Blvd St#103, Tucson, AZ 85712
(520) 886-8800 • Fax: (520) 886-8805
visiontherapy@live.com • azvisiontherapy.com

PATIENT INFORMATION

Name, Last:				Name, First:	Middle Initial:
DOB: / /	Age:	☐M ☐F	School/Occupation:		Grade:
Mailing Address:					
Email			Phone:		
How did you hear about us?			Eye Doctor:		

GUARDIAN INFORMATION (COMPLETE IF PATIENT IS A MINOR)

Mother /Guardian Name:	DOB; / / /	Address (if different from above):	Phone: (if different from above)
Occupation:		Employer:	Work Phone:
Father /Guardian Name:	DOB: / / /	Address (if different from above):	Phone:
Occupation:		Employer:	Work Phone:

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

PERMISSION TO POST PHOTOGRAPH/VIDEO/TESTIMONIAL OF PATIENT

☐Any Necessary for Office, Education or Marketing Purposes ☐Only In-Office ☐None	Initial:

PAYMENT INFORMATION

Arizona Vision Therapy Center (AVTC) is not a provider with any insurance company. I understand that I am financially responsible for all charges at/before the time of service. AVTC will provide me with invoices so I can contact my insurance company for reimbursement. By initialing, I also acknowledge that any past due balances will incur a 10% compound interest each month.	Initial:

Are you a Medicare Part B beneficiary? (Circle Yes or No and read the agreement below)

No	Yes	
To the best of my knowledge, I am not a Medicare Part B beneficiary. If in the future I become a beneficiary, I will be responsible for alerting Arizona Vision Therapy Center and completing this contract as soon as possible.	I understand that AVTC has opted out of the Medicare program effective on May 18, 2016 and that I cannot use my Medicare benefits for reimbursement of any services rendered. The Patient, or the patient's guardian, is responsible for any payments at the time services are rendered.	Initial:

Acknowledgement of Receipt of Notice of Privacy for Arizona Vision Therapy Center

Under the Health Insurance Portability and Accountability Act (HIPAA), I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices of AVTC. I also understand that AVTC has the right to change its Notice of Privacy Practices and that I may contact AVTC to obtain a current copy of such.	Initial:

I hereby authorize Arizona Vision Therapy Center to evaluate and treat the above patient. The above information is true to the best of my knowledge.

Signature (Patient, Legal Guardian, Personal Representative) Printed Name Date

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Release of Information

Patient Name:_____________________________________**Date of Birth:** ____________________

It is often beneficial to discuss evaluation and treatment information with everyone that is involved with a patient's health care and wellness. By signing this agreement, I agree to release examination treatment records to the following names listed below. This authorization shall be considered valid throughout the duration of treatment.

____ ______________________

Signature (Patient, Legal Guardian, Personal Representative) *Date*

Please list below everyone that you would like to receive evaluation and treatment information.

Optometrist	Phone/ Fax or Email
Therapist	Phone/ Fax or Email
Teacher/School	Phone / Fax or Email
Pediatrician	Phone / Fax or Email
Other (Relationship to Patient)	Phone / Fax or Email
Other (Relationship to Patient)	Phone / Fax or Email
Other (Relationship to Patient)	Phone / Fax or Email

I wish to withhold my evaluation and treatment information from the following individuals:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

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FEE SCHEDULE

Service	Fee	Service	Fee
Visual Skills Exam	**$425.00**	Progress Check	**$245.00**
Established Exam	**$340.00**	Follow Up	**$105.00**
Foot Bath (50% off 1st one)	**$ 45.00**	Cold Red Light Laser	**$ 25.00**
Foot Bath - 5 Session Package	**$215.00**	Laser - 6 Session Package	**$135.00**
Foot Bath - 10 Session Package	**$400.00**	Laser - 12 Session Package	**$275.00**
Contact Lens Fitting	**$ 65.00**	SET	**$50.00/30 min**

Sensory Learning Program / Vision Therapy / Lens Pkg / Frames **(Varies as prescribed)**

This office specializes in developmental and neurocognitive conditions. Even though we screen for gross pathology we still strongly recommend an annual examination with your regular eye doctor to ensure that your ocular eye health is stable and free from any ocular pathology.
Dilation is not typically done in this office. The exception would be if certain risk factors are present at the time of the examination. These risk factors may include diabetes, retinal detachment, uncontrolled blood pressure and high cholesterol**. If dilation is necessary, the fee is $30.00.** *After dilation, your vision may be blurry and you will be sensitive to bright light for up to 24 hours. It is strongly recommended that you do not drive if you are dilated.*

__LENS PACKAGES DO NOT INCLUDE FOLLOW UPS__ 20% off lens packages for patients enrolled in active Vision Therapy

If you must cancel your appointment, we ask that you give us a minimum of a __**24-HOUR NOTICE**__ prior to your appointment.

__**ANY LATE CANCELLATIONS, MISSED, OR NO-SHOW APPOINTMENTS WILL BE CHARGED $105.**__

_______________________________________ _______________________________________

Signature (Patient, Legal Guardian, Personal Representative) Print Name and Relationship (If not Patient) / Date

All payments are due at the time of service. Payment for Visual Skills Examinations are due at the time of the Pre-test. We accept Visa, Mastercard, HSA, ESA Funds, Check, Cash and Care Credit. Any valid discounts or special offers will be applied to your invoice on the date of service. Additional tests or procedures may be required depending on the nature of the patient's present conditions.

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VISUAL SKILLS QUESTIONNAIRE

Patient Name: ____ Date of Birth: ________________

Date: _______________________________________ Referred By: __________________________

Please answer all questions from the patient's point of view:

What concerns brought you here?

Are you currently experiencing any of the following? (Please rate Severity 0-4, 0 = none, 4 = worst)

Headaches	0	1	2	3	4
Problems Focusing	0	1	2	3	4
Double Vision	0	1	2	3	4
Eye Pain/Strain	0	1	2	3	4
Eye Fatigue	0	1	2	3	4
Words Move on Page	0	1	2	3	4
Motion/Car Sickness	0	1	2	3	4
Movement Sensitivity	0	1	2	3	4
Light Sensitivity	0	1	2	3	4
Nausea	0	1	2	3	4
Clumsiness	0	1	2	3	4
Attention Problems	0	1	2	3	4
Neck Pain/Whiplash	0	1	2	3	4
Disorientation	0	1	2	3	4
Dizziness	0	1	2	3	4
Memory Problems	0	1	2	3	4
Anxiety/Worry	0	1	2	3	4
Depression/Despair	0	1	2	3	4
Anger/Irritability	0	1	2	3	4
Overwhelm/Emotional	0	1	2	3	4
Excitement/Joy	0	1	2	3	4

How long have these symptoms been present? ____
How frequently do they occur? ☐ Always ☐ Daily ☐ Weekly ☐ Other: ____________________________
Is there anything that makes these problems worse? ___________________________________
Is there anything that makes these problems better? ___________________________________
Is it getting better, staying the same, or worsening? ______________________________________

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Please answer all questions from the patient's point of view:

Explain how your vision interferes with daily living (i.e.: home, work, hobbies, etc.):

Were there any complications during your mother's pregnancy with you? (infection, bed rest, high blood pressure, extra stressors like moving homes, changing jobs, death in family, etc.)

Were there any complications in your birth? (earlier/later than expected, forceps/vacuum removal, cesarean-section, problems with breathing, low APGARS score, etc.)

Were there any problems with your development? (missed milestones like tummy time, army crawl, creeping on all fours, walking, abnormal movement patterns like torticollis, scooting with one side of body, abnormal growth patterns, etc.)

Did you like school? Why/why not?

Did you like to read? Why/why not?

Did you like physical education (PE)? Why/why not?

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Please answer all questions from the patient's point of view:

Have you had any traumas/infections/health conditions in the past? (i.e.: traumas from death, falls, car accidents, whiplash, broken bones, etc.)
For each incident/condition, please write when it occurred, what body parts were affected, how it was treated, if the treatment worked well, current symptoms caused by it, and any other important details:

Have you ever been exposed to mold/toxins? (i.e.: mercury fillings, lead paint, remodeled home)
For each incident, write when it started, how long it was present, what has been done to help it, was the treatment successful, current symptoms caused by it, and any other important details:

Have you been diagnosed with any infections or conditions? (i.e.: pain, diabetes, high blood pressure, brain inflammation/tumor/stroke, lupus, mast cell syndrome, lyme disease, long COVID, allergies, problems with heart, thyroid, lungs, liver/gallbladder, stomach, intestines, kidney/bladder)
For each condition, write when it started, how long it was present, what has been done to help it, was the treatment successful, current symptoms caused by it, and any other important details:

What treatments have you had in the past? (chiropractor, massage, craniosacral therapy, injections, counseling, tutoring, physical therapy, occupational therapy, etc.)

What medications/supplements are you currently taking?

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Please answer all questions from the patient's point of view:

What goals do you have for a successful outcome?

Have you or anyone else ever noticed the following signs/symptoms in you over the last few months? (*Please check all that apply*)

- ☐ Frequent blinking
- ☐ Frequent eye rubbing
- ☐ Closing or covering one eye
- ☐ Eye turns in, out, up, or down
- ☐ Eyes ache, pull or tug
- ☐ Flashes of light or shadow
- ☐ Difficulty moving/turning eyes
- ☐ Difficulty changing focus
- ☐ Difficulty copying from board
- ☐ Avoids reading
- ☐ Moves head when reading
- ☐ Fatigues with near tasks
- ☐ Poor reading comprehension
- ☐ Vocalizes when reading silently
- ☐ Reads slowly
- ☐ Loses place easily while reading
- ☐ Skips, re-reads or omits words/lines
- ☐ Confuses words with same end and beginning
- ☐ Problem recognizing same word on different page
- ☐ Reverses letters or words
- ☐ Confuses right and left
- ☐ Poor recall of visual tasks
- ☐ Better recall for hearing than seeing
- ☐ Knows answers but tests poorly
- ☐ School performance below potential
- ☐ Bothered by fluorescent lights
- ☐ Bothered by headlights
- ☐ Bothered by screens
- ☐ Bothered by noises
- ☐ Bothered by touch
- ☐ Bothered by movement in environment
- ☐ Bothered by patterned wallpaper/carpets
- ☐ Difficulty with peripheral vision
- ☐ Reduced depth perception
- ☐ Dislikes heights
- ☐ Awkward/poor balance
- ☐ Difficulty following directions
- ☐ Confusion/disorientation
- ☐ Gets lost often
- ☐ Overwhelmed easily
- ☐ Bumps into things
- ☐ Drops/spills things frequently
- ☐ Dislikes/avoids sports
- ☐ Difficulty catching/hitting a ball
- ☐ Difficulty coordinating body movements
- ☐ Writes or prints poorly
- ☐ Writes neatly but slowly
- ☐ Speaking/responding slowly
- ☐ Difficulty communicating
- ☐ Slurred speech

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STRUCTURAL ENERGETIC THERAPY (SET)

We strongly recommend SET before the first appointment with the doctor. Since our vision, brain and body are all connected, completing SET first will begin to correct imbalances within the body which in turn helps the doctor complete the examination in the most efficient manner possible.

Your SET therapist will apply gentle pressure and movements to your cranium to ensure the cranial structure is optimally balanced. Once imbalances are corrected, it can help decrease physical pain, improve body function and enhance overall well-being, supporting long term health and vitality.

Please check the box if any of the following conditions apply to you:

☐ Blood thinners
☐ Pregnant (6-9 months)
☐ Recent brain surgery (less than 6 months)
☐ Shunts in ventricle to abdomen
☐ Recent concussion or TBI (less than 3 weeks)
☐ Plates crossing midline of cranium
☐ Detached retina (less than 4 months after surgery)
☐ Chiari syndrome (level 3 and 4)
☐ Recent epidural or cortisone shot in spinal column
☐ Carotid artery stents
☐ None of the above

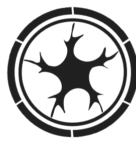
Appointment Details and Pricing:

- **Children (16 and under) $50.00** for a 30-minute session
- **Adults $100.00** for a 60-minute session

Please check one of the following boxes below:

☐ I would like to schedule a SET appointment before seeing the doctor.
☐ I do not want to schedule a SET appointment before seeing the doctor. **(Choosing to decline this treatment before seeing the doctor may extend the amount of time needed to heal your condition.)**

____
Signature *(Patient, Legal Guardian, Personal Representative)*



Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:
0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
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3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

NAME: DATE:

	Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12)	Level
1.	Difficulty with restraint and controlling impulses or desires	0 1 2 3 4
2.	Emotional instability (lability)	0 1 2 3 4
3.	Difficulty planning and organizing	0 1 2 3 4
4.	Difficulty making decisions	0 1 2 3 4
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)	0 1 2 3 4
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)	0 1 2 3 4
7.	Constantly repeat events or thoughts with difficulty letting go	0 1 2 3 4
8.	Difficulty initiating and finishing tasks	0 1 2 3 4
9.	Episodes of depression	0 1 2 3 4
10.	Mental fatigue	0 1 2 3 4
11.	Decrease in attention span	0 1 2 3 4
12.	Difficulty staying focused and concentrating for extended periods of time	0 1 2 3 4
13.	Difficulty with creativity, imagination, and intuition R	0 1 2 3 4
14.	Difficulty in appreciating art and music R	0 1 2 3 4
15.	Difficulty with analytical thought L	0 1 2 3 4
16.	Difficulty with math, number skills and time consciousness L	0 1 2 3 4
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence L	0 1 2 3 4

	Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)	Level
18.	Initiating movements with your arm or leg has become more difficult	0 1 2 3 4
19.	Feeling of arm or leg heaviness, especially when tired	0 1 2 3 4
20.	Increased muscle tightness in your arm or leg	0 1 2 3 4
21.	Reduced muscle endurance in your arm or leg	0 1 2 3 4
22.	Noticeable difference in your muscle function or strength from one side to the other	0 1 2 3 4
23.	Noticeable difference in your muscle tightness from one side to the other	0 1 2 3 4
	Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)	**Level**
24.	Difficulty producing words verbally, especially when fatigued	0 1 2 3 4
25.	Find the actual act of speaking difficult at times	0 1 2 3 4
26.	Notice word pronunciation and speaking fluency change at times	0 1 2 3 4
	Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)	**Level**
27.	Difficulty in perception of position of limbs	0 1 2 3 4
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3 4
29.	Frequently bumping body or limbs into the wall or objects accidently	0 1 2 3 4
30.	Reoccurring injury in the same body part or side of the body	0 1 2 3 4
31.	Hypersensitivities to touch or pain perception	0 1 2 3 4

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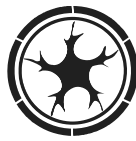

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	Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion	L	0 1 2 3 4
33.	Difficulty with math calculations	L	0 1 2 3 4
34.	Difficulty finding words	L	0 1 2 3 4
35.	Difficulty with writing	L	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes	R	0 1 2 3 4
37.	Difficulty with simple drawings	R	0 1 2 3 4
38.	Difficulty interpreting maps	R	0 1 2 3 4
	Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing		0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise		0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation		0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying		0 1 2 3 4
43.	Difficulty in localizing sound		0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music	L	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments	R	0 1 2 3 4
46.	Noticeable ear preference when using your phone		right, left, no preference
	Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words	L	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions	R	0 1 2 3 4

	Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient		0 1 2 3 4
50.	Memory loss that impacts daily activities		0 1 2 3 4
51.	Confusion about dates, the passage of time, or place		0 1 2 3 4
52.	Difficulty remembering events		0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps		0 1 2 3 4
54.	Difficulty with memory of locations (addresses)	R	0 1 2 3 4
55.	Difficulty with visual memory	R	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc.	R	0 1 2 3 4
57.	Difficulty remembering faces	R	0 1 2 3 4
58.	Difficulty remembering names with faces	L	0 1 2 3 4
59.	Difficulty with remembering words	L	0 1 2 3 4
60.	Difficulty remembering numbers	L	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left)	L	0 1 2 3 4
	Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color		0 1 2 3 4
63.	Dullness of colors in visual field		0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects		0 1 2 3 4
66.	Floater or halos in visual field		0 1 2 3 4

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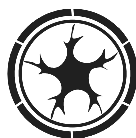

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	Cerebellum - Spinocerebellum	Level
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4
70.	Proneness to sway to one side when walking or standing	0 1 2 3 4
	Cerebellum - Cerebrocerebellum	**Level**
71.	Recent clumsiness in hands	0 1 2 3 4
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4
	Cerebellum - Vestibulocerebellum	**Level**
74.	Episodes of dizziness or disorientation	0 1 2 3 4
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4
76.	Chronic neck or back muscle tightness	0 1 2 3 4
77.	Nausea, car sickness, or sea sickness	0 1 2 3 4
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4
79.	Crowded places cause anxiety	0 1 2 3 4
	Basal Ganglia Direct Pathway	**Level**
80.	Slowness in movements	0 1 2 3 4
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4
82.	Cramping of hands when writing	0 1 2 3 4
83.	A stooped posture when walking	0 1 2 3 4
84.	Voice has become softer	0 1 2 3 4
85.	Facial expression changed leading people to frequently ask if you are upset or angry	0 1 2 3 4
	Basal Ganglia Indirect Pathway	**Level**
86.	Uncontrollable muscle movements	0 1 2 3 4
87.	Intense need to clear your throat regularly or contract a group of muscles	0 1 2 3 4
88.	Obsessive compulsive tendencies	0 1 2 3 4
89.	Constant nervousness and restless mind	0 1 2 3 4
	Autonomic Reduced Parasympathetic Activity	**Level**
90.	Dry mouth or eyes	0 1 2 3 4
91.	Difficulty swallowing supplements or large bites of food	0 1 2 3 4
92.	Slow bowel movements and tendency for constipation	0 1 2 3 4
93.	Chronic digestive complaints	0 1 2 3 4
94.	Bowel or bladder incontinence resulting in staining your underwear	0 1 2 3 4
	Autonomic Increased Sympathetic Activity	**Level**
95.	Tendency for anxiety	0 1 2 3 4
96.	Easily startled	0 1 2 3 4
97.	Difficulty relaxing	0 1 2 3 4
98.	Sensitive to bright or flashing lights	0 1 2 3 4
99.	Episodes of racing heart	0 1 2 3 4
100.	Difficulty sleeping	0 1 2 3 4

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