Arizona Vision Therapy Center

6602 E Carondelet Dr. Tucson, AZ 85710
(520) 886-8800 • Fax: (520) 886-8805
visiontherapy@live.com • AZvisiontherapy.com

BRAIN INJURY QUESTIONNAIRE

(Please fill out the questionnaire carefully.)

Patient Name: _____ Date of Birth: _____

INJURY HISTORY

Date of injury/accident: _____

Type of injury/accident (circle):

Motor vehicle	Toxic substance
Fall	Stroke / Aneurysm / Hemorrhage
Blow to head	Other:

Which area of the head was affected? _____

Was there loss of consciousness? If yes, for how long? _____

Was there a coma? If yes, how long? _____

Details of injury/accident:

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (rate from 0-4, 4 being the most severe)

						Still Present?	
Headache	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Double Vision	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Dizziness	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Pain in or around eyes	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Vomiting	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Blurred Vision	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Disorientation	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Flashes of lights	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Neck Pain/Whiplash	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Restricted Motion	**0**	**1**	**2**	**3**	**4**	**Y**	**N**
Loss of balance	**0**	**1**	**2**	**3**	**4**	**Y**	**N**

Are there any areas in space you cannot see? If so, where? _____

What is the frequency of these symptoms? _____

What makes these symptoms worse? _____

What makes them better? _____

Are they getting better, worsening or staying the same? _____

INITIAL TREATMENT

When was a doctor first seen regarding the injury? _____

Name of Doctor: _____

Where? _____

Were you hospitalized? If yes, how long? _____

What were you and your family told? _____

What did the initial treatments consist of?

What prognosis/recommendations were you given?

OTHER PROFESSIONAL CARE

Physician Name: _____

Results and recommendations:

Neurologist Name: _____

Results and recommendations:

Psychologist / Psychiatrist Name: _____

Results and recommendations:

Physical Therapist Name: _____

Results and recommendations:

Speech / Language Therapist Name: _____

Results and recommendations:

Other / Name: _____

Results and recommendations:

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

YOUR DEVELOPMENTAL HISTORY

Were there any complications during your mother's pregnancy, labor or birth with you?
If yes, explain:

Did you any problems with your development as a child?
If yes, explain:

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	_____	Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____	Cataracts	☐	☐	_____
Thyroid condition	☐	☐	_____	Blindness	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Strabismus	☐	☐	_____
Brain Tumor	☐	☐	_____	Amblyopia	☐	☐	_____
Stroke	☐	☐	_____	Traumatic brain injury	☐	☐	_____

Other:

_____

_____

List any allergies:

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

VISUAL HISTORY

Is there a previous vision evaluation?

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?:

	Yes	No	Prior to Injury?
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	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Motion sickness / car sickness	☐	☐	☐

	Yes	No	Prior to Injury?
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐

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Difficulty changing focus far to near	☐	☐	☐
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movements around you are bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper/carpets bother you	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of concentration when doing close work	☐	☐	☐
Orient writing/drawing poorly on page	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Hold books too close	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision / Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Difficulty with dressing	☐	☐	☐
Difficulty with bathing / personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion / disorientation	☐	☐	☐
Get lost often	☐	☐	☐

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Bothered by noises	☐	☐	☐
Bothered by touch	☐	☐	☐

Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐
Difficulty recalling past information	☐	☐	☐
Difficulty remembering formerly familiar people / objects	☐	☐	☐
Difficulty performing tasks formerly easy / routine	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

LIFESTYLE

Do you feel your vision interferes with activities of daily living?
If yes, please explain (including home, work, school, social and/or personal life):

What activities comprise most of your daily life since the injury?

What activities can you no longer engage in due to the visual difficulties?

What do you hope a Visual Rehabilitation Program can do for you?

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I hereby authorize Arizona Vision Therapy Center to treat:

_____

_____

_____

(Print Patient Name)

_____

_____

_____

(If minor print Parent/Guardian's Name)

_____

_____

Patient or Parent/Guardian Signature *Date*

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PATIENT INFORMATION

Name, Last:	Name, First:	Middle Initial:

DOB: / /	Age:	☐M ☐F	School/Occupation:	Grade:

Mailing Address:

Email	Phone:

Referred By:	Eye Doctor:

GUARDIAN INFORMATION (COMPLETE IF PATIENT IS A MINOR)

Mother /Guardian Name:	DOB: / /	Address (if different from above):	Phone:
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? (Check 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 became 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.

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:

The above information is true to the best of my knowledge.

_____ _____ _____

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

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Primary Medical Insurance

Primary Member: _____ DOB: _____/_____/_____

Plan Provider: _____

Member ID#: _____

SSN: _____

Patient Relation: _____

EXAM SRVICES

Visual Skills Exam:
$360.00

Regular Eye Exam:
$180.00

Sensory Learning Program (Pre-test):
$260.00

Contact Lens Fitting: **$60.00**

Follow-Up: **$60.00**

Dilation Fee: **$20.00**

****(Follow/Ups are NOT included with Visual Skills and Regular Eye Exams) ****

_____ _____ Signature (Patient, Legal Guardian, Personal Representative)

**Payment is due at time of service. If applicable discounts/special offers will be applied to your service. Additional tests or procedures may be required depending on the nature of the patient's present conditions.