New England College of Optometry
CENTER FOR EYE CARE

ADULT VISION HEAD TRAUMA/CONCUSSION QUESTIONNAIRE

Please fill out this questionnaire and return it to the clinic prior to your appointment.

GENERAL INFORMATION

Patient's Name: _____ Gender: _____
Birth Date: _____ Age: _____
Home Address: _____City/State:_____ Zip: _____
Home Phone: _____ Work Phone:_____
Cell Phone: _____
Email: _____
Social Security Number: _____ Driver's License No.:_____
Marital status: _____ Occupation: _____
Employer: _____ Business Phone: _____
Business Address: _____ City/State: _____ Zip: _____
Spouse/Partner's Name: _____ Cell Phone: _____
Spouse/Partner's Occupation: _____
Spouse/Partner's Employer: _____ Business Phone: _____
Business Address: _____ City/State: _____ Zip: _____

Whom may we thank for this referral? _____
Address: _____ Phone: _____

MEDICAL HISTORY

Date of injury/accident: _____
Type of injury/accident: Motor vehicle ☐ Fall ☐ Blow to head ☐ Industrial Accident ☐
Medication-related ☐ Drug abuse ☐ Poison or toxic substance ☐ Carbon dioxide ☐
Drowning ☐ Cord around neck ☐ Stroke ☐ Aneurysm ☐ Hemorrhage ☐
Other: _____
Is this injury/accident work-related? _____

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? _____
List any medications, including vitamins and supplements, you were taking at the time of your accident/injury: _____

Symptoms immediately following accident/injury: (check all that apply)
Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐ Dizziness ☐
Vomiting ☐ Flashes of light ☐ Disorientation ☐ Loss of balance ☐ Neck pain/whiplash ☐
Loss of memory ☐ Restricted field of view ☐ Restricted motion ☐
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(s): _____

_____

For what condition(s)? _____

SUBSEQUENT/OTHER PROFESSIONALCARE

What types of professional care have you received or are you currently receiving?

Physician Name: _____ Date: _____

Results and recommendations: _____

Physiatrist Name: _____ Date: _____

Results and recommendations: _____

Neurologist Name: _____ Date: _____

Results and recommendations: _____

Neuropsychologist 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: _____

Osteopathic Physicians Name: _____ Date: _____

Results and recommendations: _____

Other/Name: _____ Date: _____

Results and recommendations: _____

MEDICAL HISTORY

Medications, including vitamins and supplements, currently using: _____

_____

For what condition(s): _____

Current diet restrictions and/or concerns: _____

_____

Do you have a history of allergies? Yes ☐ No ☐

If yes, please explain: _____

Is there any history of the following? (please check all that apply)

	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	☐	☐	_____

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:

	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	☐	☐	☐
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐

	Yes	No	Prior to Injury?
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of interest/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	☐	☐	☐
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 information known in the past	☐	☐	☐
Difficulty remembering formerly familiar people/objects	☐	☐	☐
Difficulty performing tasks formerly easy/routine	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

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

_____

_____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? 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? _____

_____

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? _____

How many hours daily are spent with a smart phone/tablet? _____

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs. If you would like to communicate via email, please complete and sign the Authorization to Email Protected Health Information form located on the website. Completed questionnaires can be mailed or faxed to:

NECO Center for Eye Care
930 Commonwealth Ave.
Boston, MA 02215
Fax: 617-396-8517

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day/7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Celia Hinrichs, O.D., FCOVD
Gayathri Srinivasan, OD, MS, FAAO