New England
College of Optometry

CENTER FOR EYE CARE

TEENAGE HEAD TRAUMA/CONCUSSION VISION QUESTIONNAIRE

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

Patient's Name: ______________________________ Gender: __________
Birth Date: ______________________________ Age: ______ years ______ months

RESPONSIBLE PERSON INFORMATION

Parent/Caretaker: ______________________________ Birth Date: ______________
Parent/Caretaker: ______________________________ Birth Date: ______________
Home Address: ______________________________ City/State:__________ Zip: ________
Home Phone: ______________________ Cell Phone: ______________________
Email: ____
Parent/Caretaker's Occupation: ______________ Business and/or cell Phone: ______________
Business Address: ______________________________ City/State: __________Zip: ________
Parent/Caretaker's Occupation: ______________ Business and/or cell Phone: ______________
Business Address: ______________________________ City/State: __________Zip: ________

Please list the names and birth dates of your family:
Sibling: ______________________________Birth Date: ______________
Sibling: ______________________________Birth Date: ______________
Sibling: ______________________________Birth Date: ______________

Whom may we thank for this referral? ______________________________
Address: ______________________________ Phone: ______________
Name and address of child's school: ______________________________
Grade:__________
Dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

PRESENT SITUATION

Why do you feel you need a visual evaluation? ______________________________
How long has this problem/difficulty been observed? ______________________________
Is this problem/difficulty a result of a work-related injury/accident? ______________________
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? ____
____

VISUAL HISTORY

Has your vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: ______________________ Date of last evaluation: ______________
Reason for examination: ____

Results and recommendations: ____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? ____
Are they used? Yes ☐ No ☐ If yes, when? ____
If not used, why not? ____

Members of the family who have had visual problems:

Name	Age	Visual Situation

CONCUSSION 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: ____

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: ____________________

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Was This 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	☐	☐	☐
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	☐	☐	☐

	Yes	No	Was This Prior To Injury?
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	☐	☐	☐

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? ____________________________

____

MEDICAL HISTORY

Pediatrician's Name: ___________________________ Date of Last Evaluation: _______________

Diagnoses and recommendations: ____

Your current state of health: ____

Medications <u>currently using</u>, including vitamins and supplements: ___________________________

____

For what condition(s)? ____

____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: ___________________________

List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

Are there any chronic problems like colds, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list/explain: ____

____

____

Current diet restrictions and/or concerns: ____

____

Is there any known history of problems with the following?

	Patient	Family	Who		Patient	Family	Who
Eyes	☐	☐	______	Hematological/lymphatic	☐	☐	_____
Ears, Nose, Throat	☐	☐	______	Neurological	☐	☐	_____
Cardiovascular health	☐	☐	______	Endocrine Disorder	☐	☐	_____
Respiratory	☐	☐	______	Genitourinary	☐	☐	_____
Gastrointestinal health	☐	☐	______	Skin	☐	☐	_____
Psychiatric	☐	☐	______	Musculoskeletal	☐	☐	_____
Allergic/immunologic	☐	☐	______	Brain Tumor	☐	☐	_____

	Patient	Family	Who	P	Patient	Family	Who
Diabetes	☐	☐	______	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	______	Learning Issues	☐	☐	_____
Chromosomal Imbalance	☐	☐	______	Amblyopia (lazy eye)	☐	☐	_____
Thyroid Condition	☐	☐	______	Multiple Sclerosis	☐	☐	_____
Glaucoma	☐	☐	______	Epilepsy or Seizures	☐	☐	_____
Macular Degeneration	☐	☐	______	Autism Spectrum Disorder	☐	☐	_____

If other, please explain: ____

____

Any learning problems in the family? ____

DEVELOPMENTAL HISTORY:

Adopted: Yes ☐ No ☐ age when adopted_____ country of origin_____________

Does the teenager know that he/she was adopted? Yes ☐ No ☐

Full-term pregnancy? Yes ☐ No ☐

Did the birth mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, explain: ____

Was there ever any reason for concern over general growth or development?

Yes ☐ No ☐.

If yes, why? ____

TELEVISION/COMPUTER/TABLET/SMART PHONE VIEWING/LEISURE TIME ACTIVITIES

Do you watch TV? _________ How much? _______ How often? _______ Viewing distance? _______

Do you spend time using computer/tablet/smart phone/video games? Yes ☐ No ☐

If yes, how much? ___________ How often? ___________ Viewing distance? ___________________

What activities do you do on your smart phone? ____

Watch videos? ☐ Texting? ☐ Write papers? ☐

What other activities occupy your leisure time? ____

Are there any activities you would like to participate in, but don't? ___

Please explain: ____

____

SCHOOL

Do you like school? Yes ☐ No ☐

Specifically describe any school difficulties: ____

____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? ____

Do you seem to be under tension or extreme pressure
when doing school work? Yes ☐ No ☐

Have you had any special tutoring, therapy, and/or remedial assistance? .... Yes ☐ No ☐

If yes, when? ____

Where and from whom? ____

Do you like to read? Yes ☐ No ☐

Voluntarily? Yes ☐ No ☐

Do you read for pleasure? Yes ☐ No ☐

What? ____

What is your attitude toward reading, school, your teachers, peers? ___________________________

____

Overall schoolwork is: above average ☐ average ☐ below average ☐

WHICH SUBJECTS ARE:

Above average: ____

Average: ____

Below average: ____

Do you need to spend a lot of time/effort to maintain this level of performance?

Yes ☐ No ☐

How much time on average do you spend each day on homework assignments? ________________
To what extent do you get assistance with homework? ____
Do you feel you are achieving up to your potential? Yes ☐ No ☐
Do you think your teachers feel you are achieving up to your potential? Yes ☐ No ☐

FAMILY AND HOME
Please indicate which adult(s) you live with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): ______________________________
Do you spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: ____
How do you get along with:
Parents/other caretakers? ______________Siblings? ______________________________
Classmates in school?

Have you ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: __________________________
Was counseling/therapy undertaken? Yes ☐ No ☐ If yes, is it on-going? Yes ☐ No ☐
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: ____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR TEENAGER?

____
____
____
____
____

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 of your child and to better meet your child's 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 you have any questions on concerns that we may answer prior to your appointment, please do not hesitate to contact us.

Thank you,

Celia Hinrichs, O.D., F.C.O.V.D.
Gayathri Srinivasan, OD, MS, FAAO