

# Alderwood

## Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a comprehensive vision examination. On the following pages you will find a "Vision Rehabilitation Questionnaire". **Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the examination.**

Thank you again for your cooperation in providing this complete history.  
We look forward to seeing you!

16006 Ash Way, Suite 101, Lynnwood, WA 98087  
Phone: (425) 787-5200 Fax: (425) 787-5252

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**Nancy G. Torgerson**  
Doctor of Optometry

# DRIVING DIRECTIONS

Alderwood Vision Therapy Center, PLLC  
16006 Ash Way, Suite #101  
Lynnwood, WA 98087  
(425) 787-5200

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## **Southbound on I-5 coming from Everett, WA**

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **Northbound on I-5 coming from Seattle, WA**

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **Northbound on I-405**

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

## **From the Edmonds Ferry:**

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

**Our office is located in a separate building at the north end of Newberry Square.**

## VISION REHABILITATION QUESTIONNAIRE

*Please fill out this questionnaire carefully.*

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient's Name: \_\_\_\_\_

### GENERAL INFORMATION

Were you referred to our office? Yes  No

If yes, whom may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ Profession: \_\_\_\_\_

Patient's Full Legal Name: \_\_\_\_\_ Male  Female

Patient's Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Marital status: Single  Married  Divorced  Widowed

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_

### INSURANCE

Do you have Vision Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group#: \_\_\_\_\_

Do you have Medical Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group#: \_\_\_\_\_

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S)  
WITH YOU TO YOUR APPOINTMENT.**

**MEDICAL HISTORY**

Date of injury/accident: \_\_\_\_\_

Type of injury/accident:

- Motor vehicle       Medication-related       Cord around neck       Stroke
- Fall       Drug abuse       Industrial Accident       Aneurysm
- Blow to head       Poison/toxic substance       Carbon dioxide       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? \_\_\_\_\_

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

- Double vision       Vomiting       Flashes of light       Neck pain/whiplash
- Headache       Restricted motion       Disorientation       Loss of memory
- Blurred vision       Pain in/around eyes       Loss of balance       Restricted field of view
- Dizziness       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: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

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

Do you have any allergies to medications? \_\_\_\_\_

**SUBSEQUENT/OTHER PROFESSIONAL CARE**

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

- Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Psychiatrist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Neurologist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Neuropsychologist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Osteopathic Physician's 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: \_\_\_\_\_

Other / Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Results and recommendations: \_\_\_\_\_

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

Do you have a history of allergies? Yes  No   
 If yes, please explain: \_\_\_\_\_

Has a neurological evaluation been performed? Yes  No   
 If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_

Has a psychological evaluation been performed? Yes  No   
 If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_

Has a speech and language evaluation been performed? Yes  No   
 If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_

Do you have a seizure disorder? Yes  No

Do you have a sleep disorder? Yes  No

**MEDICAL HISTORY**

**Have you or a family member been treated for any condition related to:**

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematological/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Specifically, is there any history of the following: (please check if there is a history)**

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SOCIAL HISTORY**

Do you smoke? Yes  No  What do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you drink? Yes  No  What do you drink? \_\_\_\_\_ How much per day? \_\_\_\_\_

Do you use recreational drugs? Yes  No  What Drug? \_\_\_\_\_ How often? \_\_\_\_\_

**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:**

	<u>Yes</u>	<u>Prior to Injury</u>
Eyes ache	<input type="checkbox"/>	<input type="checkbox"/>
Eyes pull or tug	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain with movement of eyes	<input type="checkbox"/>	<input type="checkbox"/>
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>
Pain in or around eyes	<input type="checkbox"/>	<input type="checkbox"/>
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Brightness is bothersome	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision at near	<input type="checkbox"/>	<input type="checkbox"/>
Tunnel vision / Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>
Avoid reading or writing	<input type="checkbox"/>	<input type="checkbox"/>
Words jump or move around when reading	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span for reading or writing	<input type="checkbox"/>	<input type="checkbox"/>
Skip words frequently when reading	<input type="checkbox"/>	<input type="checkbox"/>
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>
Movement of objects in the environment is bothersome	<input type="checkbox"/>	<input type="checkbox"/>
Fluorescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>

Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>
Objects jump in and out of field of view	<input type="checkbox"/>	<input type="checkbox"/>
Reduced depth perception	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>
Head tilts during desk work	<input type="checkbox"/>	<input type="checkbox"/>
Hold books too close	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty changing focus far to near	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with bathing / personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty following a series of directions	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty using both sides of the body together	<input type="checkbox"/>	<input type="checkbox"/>
Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>
Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Confusion / disorientation	<input type="checkbox"/>	<input type="checkbox"/>
Get lost often	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by noises	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by touch	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things heard	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering name of objects	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty recalling information known in the past	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering formerly familiar people / objects	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty performing tasks formerly easy / routine	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with time management	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty counting money	<input type="checkbox"/>	<input type="checkbox"/>

**LIFESTYLE**

Do you feel your vision interferes with activities of daily living? Yes  No

Is this new since the accident/injury? 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? \_\_\_\_\_

\_\_\_\_\_

What goals have you set up that you would like us to help you meet? What are your short term and long term goals? \_\_\_\_\_

\_\_\_\_\_

### **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? \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_