ALDERWOOD VISION THERAPY CENTER, PLLC Drs. Torgerson, Murphy, Maher, Hash, & Schiller
16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

Dr. Initials/Date: ______ /_______

SUPPLEMENTAL VISION REHABILITATION QUESTIONNAIRE

Appointment Date: ___ /___ /___

Full Legal Name: ___________________________ Date of Birth: ___ /___ /___ Age: _______

GENERAL INFORMATION

Date of injury/accident: ___ /___ /___ What State did the injury/accident occur in? (e.g., WA): ______________

Did this injury/accident occur at work? Yes ☐ No ☐
If yes, out of work from: ___ /___ /___ to ___ /___ /___

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? Please check all that apply below:

☐ Forehead ☐ Back of head ☐ Right side
☐ Face ☐ Top of head ☐ Left side

Was the injury Open-head (bleeding) Yes ☐ No ☐
Was the injury Closed-head (non-bleeding) Yes ☐ No ☐

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 the accident/injury. Please check all that apply below:

☐ 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 currently: ______________________________

____

Do you have any allergies to medications? Yes ☐ No ☐ Medication: ______________________________

SUBSEQUENT/OTHER PROFESSIONAL CARE

Has a neurological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________ When? ____________
Results: ______________________________

Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________ When? ____________
Results: ______________________________

Has a speech and language evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________ When? ____________
Results: ______________________________

Has a visual evaluation been performed following the injury? Yes ☐ No ☐
If yes, by whom? ______________________________ When? ____________
Were any additional vision tests, treatments, and/or therapies recommended? Yes ☐ No ☐
If yes, what? ______________________________
Did you undergo these recommendations? Yes ☐ No ☐
Results: ______________________________

What types of other professional care have you received or are you currently receiving? Please check all that apply below and describe:

☐ Physicians Name: ______________________________ Date: ____________
Results and recommendations: ______________________________

☐ Physiatrist 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: ______________________________

☐ Other / Name: ______________________________ Date: ____________
Results and recommendations: ______________________________

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?____

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Today's Date: ___ /___ /___

Print Name: ____

Signature: ____