

ALDERWOOD VISION THERAPY CENTER, PLLC

Drs. Torgerson, Murphy, Maher, & Hash

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 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? _____

Today's Date: ____ / ____ / ____

Print Name: _____

Signature: _____

