wow vision therapy

Developmental Vision and Rehabilitation

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HEAD TRAUMA HISTORY

Name | Date

Referred by _____

General Information

Home Phone _____ Cell Phone _____
Fax Number _____ E-Mail _____
Home Address _____
City _____ State _____ Zip _____
Social Security Number _____ Age _____
Birth Date _____ Sex ☐M ☐F Marital Status ☐S ☐M ☐D ☐W
If Married, Spouse's Name _____
Emergency Contact _____
Name of Health Care Plan _____
Policy/Group Number _____

Medical History

Date of injury _____ Explanation of injury _____
_____
Date of most recent medical examination _____ Name of physician _____
Medications currently taking _____
For what conditions _____

Please check any of the following professionals that you have seen related to your injury:

☐ Physiatrist	☐ Psychiatrist	☐ Family Physician	☐ Neurologist
☐ Osteopath	☐ Speech Therapist	☐ Psychologist	☐ Chiropractor
☐ Physical Therapist	☐ Massage Therapist	☐ Neuropsychologist	☐ Ophthalmologist
☐ Emergency Room Doctor	☐ Audiologist/Otolaryngologist	☐ Occupational Therapist	☐ Other

Any history of the following, please check

	You	Family		You	Family
High Blood Pressure	☐	☐	Multiple Sclerosis	☐	☐
Glaucoma	☐	☐	Brain Tumor	☐	☐
Diabetes	☐	☐	Lazy eye/Amblyopia	☐	☐
Cataracts	☐	☐	Stroke	☐	☐
Thyroid Condition	☐	☐	Brain Injury	☐	☐
Blindness	☐	☐			

Do You Experience Any of the Following, Please Check

	Yes	No		Yes	no
Brightness bothers you	☐	☐	One eye turns in or out	☐	☐
Difficulty in stores or malls	☐	☐	Squinting, covering or closing one eye	☐	☐
Motion sickness	☐	☐	Burning eyes	☐	☐
Head turns as reading across page	☐	☐	Tilting head during desk work	☐	☐
Eye ache	☐	☐	Eye drainage	☐	☐
Losing place often when reading	☐	☐	Fatigues easily	☐	☐
Headaches	☐	☐	Itching eyes	☐	☐
Using finger to keep place	☐	☐	Holding books too closely	☐	☐
Blurred vision	☐	☐	Delayed dressing skills	☐	☐
Short attention span for close work	☐	☐	Avoid near tasks	☐	☐
Eye redness	☐	☐	Dislike heights	☐	☐
Skipping words frequently when reading	☐	☐	Difficulty following series of directions	☐	☐
Double vision	☐	☐	Awkward, poor balance	☐	☐
Orient drawing poorly on page	☐	☐	Difficult using both sides of body together	☐	☐

Motor Vehicle Accident

Type of vehicle you were in _____ Other vehicles involved _____

Were you sitting in ☐ Front seat ☐ Back seat ☐ Middle

Seat relative location ☐ Left side ☐ Right side ☐ Unusual position

Which restraints were used ☐ Lap ☐ Shoulder ☐ Car seat ☐ Booster seat ☐ Air bag

Speed of vehicle you were in _____ Speed of other vehicle or object _____

Did your vehicle hit another object ☐ Yes ☐ No

Or, did the other vehicle hit your vehicle ☐ Yes ☐ No

If yes where was your vehicle hit ☐ Head on ☐ Toward front ☐ Driver's side

☐ Rear ended ☐ Toward rear ☐ Passenger's side

Did you experience whiplash ☐ Yes ☐ No

Did you hit your head ☐ Yes ☐ No

If yes, on what _____