J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.

WALESBY VISION CENTER
"Where Vision Is More Than Just 20/20"

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully & completely & submit it to our office ***FOUR BUSINESS DAYS PRIOR*** *to your Screening or Work-Up appointment. Thank you.*

Appointment Date: ______________________ Time: ____________
Patient's Name: ____

REFERRED BY:

Eye Doctor: ______________________ Address: ______________________
OT: ______________________ City, State Zip: ______________________
Psychologist: ______________________ Phone # : (___)____-________
Other (specify): ____

GENERAL INFORMATION

Full Name: ______________________________ Male ☐ Female ☐
Birth Date: __________ Age: _____ Social Security Number: _____-_____-________
Home Address: ______________________ City: ______________ Zip: _______
Primary Phone #:(___) ____-______ Alternate Phone #:(___)____-_______ Fax #:(___) ____-______
Patient/ Father/ Guardian Occupation: ______________________ Work/Cell #: (___)____-______
Patient/ Father/ Guardian Email: ______________________@___________.______
Spouse/Mother Occupation: ______________________ Work/Cell #: (___) ____-_______
Spouse/ Mother Email: ___________________@__________._____

FAMILY MEMBERS

NAME

Father/ Guardian/ Spouse: ______________________ Birth Date: ______________
Mother/ Guardian: ______________________ Birth Date: ______________
Dependent/ Sibling: ______________________ Birth Date: ______________
Dependent/ Sibling: ______________________ Birth Date: ______________
Dependent/ Sibling: ______________________ Birth Date: ______________

SCHOOL INFORMATION (If applicable)

Name of school: ______________________ Location: ______________________
Grade: _________ Teacher 1: ______________________ Teacher 2: ______________________
Guidance Counselor: ______________________ Principal: ______________________
Child's dominate hand: Right ☐ Left ☐ Has guidance been given in use of hand? Yes ☐ No ☐

MEDICAL HISTORY

Date of injury/accident: ____/____/______

Type of injury/accident: Motor vehicle ☐ Fall ☐ Medication-related ☐
Industrial Accident ☐ Blow to head ☐ Drug abuse ☐
Carbon dioxide ☐ Drowning ☐ Poison or toxic substance
Cord around neck ☐ Stroke ☐ Aneurysm ☐
Hemorrhage ☐ Other: ______________________________

WHAT PART OF THE 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) ☐ ?

Was there loss of consciousness? Yes ☐ No ☐ If yes, for how long? ______________

Were you/ your child in a coma? Yes ☐ No ☐ If yes, how long? ______________

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

Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐
Disorientation ☐ Vomiting ☐ Loss of balance ☐ Loss of memory ☐
Flashes of light ☐ Dizziness ☐ Restricted field of view ☐ Neck pain/whiplash ☐
Other: ____

INITIAL TREATMENT

When did you/your child first see a doctor regarding the accident/injury? ______________

Doctor's Name: ______________________ Specialty: ______________

Facility Name: ______________ Was there Hospitalization? Yes ☐ No ☐ how long?________

What was the prognosis?______________________________

What did the initial treatments consist of? ______________________________

What recommendations? ______________________________

What medications were given? (Please list): ______________________________

____

for what condition(s)? ______________________________

List any other medications, including vitamins and supplements used at the current time: __________

____

SUBSEQUENT/OTHER PROFESSIONALCARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU/YOUR CHILD RECEIVED OR ARE CURRENTLY RECEIVING?

Physicians 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: ______________________________

Speech / Language Therapist Name: ______________________ Date: __________

Results and recommendations: ______________________________

Psychologist / Psychiatrist Name: ______________________ Date: ________
Results and recommendations: ______________________
Osteopathic Physician Name: ______________________ Date: ________
Results and recommendations: ______________________
Other / Name: ______________________ Date: ________
Results and recommendations: ______________________

Any history of allergies? Yes ☐ No ☐
If yes, please explain: ______________________
Has a neurological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
If yes, by whom? ______________________ Date: ________
Results: ______________________
Has a psychological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
If yes, by whom? ______________________ Date: ________
Results: ______________________
Has a speech and language evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
If yes, by whom? ______________________ Date: ________
Results: ______________________

MEDICAL HISTORY

Is there any history of the following? (Please check if there is a history)

	Patient	Family (Who)		Patient	Family (Who)
Diabetes	☐	________	High Blood Pressure	☐	☐ ________
"Cross" or "Wall" eye		________	Learning Disability	☐	☐ ________
Chromosomal Imbalance	☐	________	Amblyopia (lazy eye)		________
Glaucoma		________	Multiple Sclerosis	☐	☐ ________
Brain Tumor	☐	________	Epilepsy or Seizures		________
			Other		________

VISUAL HISTORY

Has your/your child's 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 worn currently? Yes ☐ Full time ☐ Distance only ☐ Near only ☐
No ☐ explain: ______________________
Were any additional tests, treatments, or therapies recommended concerning your vision?
Yes ☐ No ☐ If yes, what? ______________________
Did you/your child undergo these treatments? Yes ☐ No ☐ Explain: ______________________
____
____
Results and recommendations: ______________________
____
____

DO YOU/YOUR CHILD CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?

	Yes	No	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	☐	☐	☐
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	☐	☐	☐

	Yes	No	Prior to Injury?
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/routines formerly easy	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

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

____

____

____

____

LIFESTYLE

Do you feel your/your child's 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 condition(s) comprise your/your child's daily life since the accident/injury? ____________

____

____

What activities can you/your child no longer engage in due to your/his/her visual or other difficulties?

____

____

What other changes/limitations in your/your child's daily life are attributed to the accident/injury?

____

____

What do you hope a Visual Rehabilitation Program can do? ______________________

____

____

EMPLOYMENT/EDUCATION INFORMATION (If applicable)

What is your 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? ______________________

SCHOOL (If applicable)

Age at time of entrance to: Pre-school: ________ Kindergarten: ________ First Grade: ________
Does he/she like school? Yes ☐ No ☐
Does he/she like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐ For pleasure? Yes ☐ No ☐
What: ______________________
What is his/her attitude toward reading, school, teacher(s), peers? ______________________
____
Overall school work is: above average ☐ average ☐ below average ☐
Specifically describe any school difficulties: ______________________
____
Has he/she changed schools often? Yes ☐ No ☐ If yes, when? ______________________
Has a grade been repeated? Yes ☐ No ☐ If yes, which and why? ______________________
____
Does he/she seem stressed or pressured when doing schoolwork? Yes ☐ No ☐
Has he/she had tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, from whom: ______________ Title: (OT, PT, SLP, etc.) ______________
Currently attending? Yes ☐ No ☐ How long: ______________ How Often: ______________
Address: ______________________
Results: ______________________

WHICH SUBJECTS ARE:

Above average: ______________________
Average: ______________________
Below average: ______________________
Does he/she spend excessive time/effort to maintain this level of performance? Yes ☐ No ☐
How much time (average) is spent on homework daily? ______________________
To what extent do you assist him/her with homework? None ☐ Partial ☐ Full ☐
Do you feel he/she is achieving up to full potential? Yes ☐ No ☐
Does his/her teacher feel that he/she is achieving up to full potential? Yes ☐ No ☐

TELEVISION VIEWING/LEISURE TIME ACTIVITIES (If applicable)

Does child watch TV? ________ How much? ________ How often? ________ Viewing distance? ________
Does he/she spend time using computer/video games? Yes ☐ No ☐
If yes, how much? ____________ Frequently: ____________ Viewing distance: ____________
What other activities occupy his/her leisure time? ______________________
Are there any activities he/she would like to participate in, but doesn't? ______________________
Please explain: ______________________
____

RELEASE OF INFORMATION

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION REGARDING YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit copies of my/my child's examination records to be forwarded to other health care providers or insurance carriers upon written request or recommendation of the WALESBY VISION CENTER when deemed necessary for treatment of my/his/her visual condition, or processing of insurance claims.

____________________________________ ____________
Patient/ Parent's/ Guardian's Signature Date

I do hereby give my permission to the WALESBY VISION CENTER to treat ______________________
(Child's Name)

____________________________________ ____________
Parent's/ Guardian's Signature Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information provided allows for a more efficient use of time, enabling us to perform a more comprehensive evaluation and better meet his/her specific visual needs.

If you have questions or concerns prior to your appointment, please do not hesitate to contact us.

A minimum cancellation notice of 48 hours is required, as previously agreed, or a $360 service charge will be processed. You may leave a voicemail at our office number at any time.

Please be prompt for the appointment in order to maximize the time reserved to evaluate your/his/her visual status.

Your undivided attention is necessary during this evaluation; it is, therefore, advisable not to bring other children.

Your child may benefit from bringing something to occupy his/her time while you are in conference with the doctor.

Sincerely,

J. Robert Walesby, O.D., F.C.O.V.D.
Shereé Wright, O.D.

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

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