TBI/Post Concussion Questionnaire

Please fill out this questionnaire carefully. Thank you.

Patient's Name _____ Age _____ D.O.B. _____

Whom may we thank for referring you to our office?_____

Email _____Occupation_____

Chief Complaint_____

When did it start?_____

MEDICAL HISTORY

Date of most recent medical exam_____ Doctor's name_____

Reason/results _____

List any medications_____

List any bad falls, head injuries, car accidents and/or stroke, and year of occurrence:_____

_____

_____

List any chronic problems _____

_____

Has a *neurological* and/or *psychological* evaluation been performed (please circle)?

By whom/Results?_____

Any current or past *Occupational, Physica*l and/or *Speech* Therapy (please circle)?

By whom/Results?_____

Is there any history of the following?

	Self	Family		Self	Family		Self	Family
Eye Turn/Strabismus	☐	☐	Lazy Eye/Amblyopia	☐	☐	Glaucoma	☐	☐
Macula degeneration	☐	☐	Dry/Red Eyes	☐	☐	Diabetes	☐	☐
Reading disabilities	☐	☐	Other visual conditions_____					

VISION THERAPY

VISUAL HISTORY

When and who performed your the last eye exam:_____

If you wear glasses, please answer the questions below.

Age of glasses #1 _____ Are they: Progressive, Distance, Computer, Reading or Prescription Sunglasses?

Any concerns with them? _____

Age of glasses #2 _____ Are they: Progressive, Distance, Computer, Reading or Prescription Sunglasses?

Any concerns with them? _____

Age of glasses #3 _____ Are they: Progressive, Distance, Computer, Reading or Prescription Sunglasses?

Any concerns with them? _____

If you wear contact lenses*, please write the brand and power of the lenses.*

_____

Have you worn "***binasal occlusion***" where tape is applied to inner part of your glasses? Y N

Past eye surgeries?

Date_____Type_____ Which Eye_____ Surgeon_____

Date_____Type_____ Which Eye_____ Surgeon_____

If you have double vision, please answer the questions below.

- When did it start?_____
- Is the double image(please circle): side by side, diagonal, up and down or it varies in direction?
- Is the double vision occurring when looking at near or far distance? _____
- When does it occur? morning, night, driving, reading, computer, all day _____
- Does the double image disappear if you close one eye? Y N
- Does your glasses help eliminate your double vision? Y N

VISION THERAPY

Traumatic Brain Injury & Post Concussion Syndrome

Symptom Survey

Initial Exam Date: _____ Current Exam Date: _____

Initial Subjective Score: _____ Post Subjective Score: _____

(Please fill out information <u>below</u> here)

Patient: _____

Age: _____ Date of Injury: _____

Cause of Injury: _____

Location of Head injury: _____

#1 Symptom: _____

#2 Symptom:_____

	Never					Constant/Always
Blurry Vision in the distance	0	1	2	3	4	5
Blurry Vision when reading	0	1	2	3	4	5
Fluctuating/inconsistant vision	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Photophobia (light sensitivity)	0	1	2	3	4	5
Phonophobia (hearing sensitivity)	0	1	2	3	4	5
Double vision	0	1	2	3	4	5
Loses place while reading	0	1	2	3	4	5
Words appear to run together when reading	0	1	2	3	4	5
Poor Memory, forgetful	0	1	2	3	4	5
Attention/Concentration difficulties	0	1	2	3	4	5
Visual memory difficulty	0	1	2	3	4	5
Vision is worse at the end of the day	0	1	2	3	4	5
Rereads reading material in order to comprehend	0	1	2	3	4	5
Difficulty with eye tracking	0	1	2	3	4	5
Eye fatigue	0	1	2	3	4	5
Mental fatigue	0	1	2	3	4	5
Physical fatigue	0	1	2	3	4	5
Spatial disorientation	0	1	2	3	4	5
Night vision worse than day vision	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Flashes of light	0	1	2	3	4	5
Irratability	0	1	2	3	4	5
Emotional distress/anxiety	0	1	2	3	4	5
Balance issues	0	1	2	3	4	5
Vertigo/Nausea	0	1	2	3	4	5
Car/motion sickness	0	1	2	3	4	5
Sleep disturbances	0	1	2	3	4	5
Disordered thinking	0	1	2	3	4	5
Walking difficulties	0	1	2	3	4	5
Poor depth perception	0	1	2	3	4	5

Total Score: _____