ADVANCED EYECARE AND THERAPIES
104 S FREYA ST. SUITE #220, WHITE FLAG BLDG.
SPOKANE, WA 99202

D . TODD WYLIE O.D., F.C.O.V.D.
Phone 509-535-5855
Fax 509-535-3916

VISION REHABILITATION QUESTIONNAIRE

*Please fill out this questionnaire carefully. Please return it to our office **prior** to your appointment. THANK YOU*

Appointment: Day_____ Date _____ Time _____
Patients Name: First_____ MI_____ Last_____
Date of Birth: _____ Age: _____ Male _____ Female _____
Home Address: _____
Cell Phone: _____Home Phone: _____ Work Phone: _____
Email address: _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
Were you referred to our office? Yes _____ No _____
If yes, whom may we thank for this referral?_____ Phone _____
Do you have Major Medical Insurance? Yes _____ No _____
If yes, who is the carrier?_____ Policy #_____
Do you have Vision Insurance? Yes _____ No _____
If yes, who is the carrier?_____ Policy #_____
Is this work related? Yes _____ No _____ If Yes, claim number _____
Adjustor's name:_____ Phone _____
Primary Insurance:_____ Policy #_____
Secondary Insurance: _____ Policy #_____
Social Security Number: _____
What is your occupation: _____
Employer:_____
Spouse's Name:_____ Spouse's phone number:_____

POST INJURY HISTORY

Date of Injury/Accident: _____
Type of Injury/Accident: Motor Vehicle ___ Fall ___ Blow to head ___ Industrial accident ___
Medication related ___ Drug abuse ___ Poison or toxic substance ___ Carbon dioxide ___
Drowning ___ Cord around neck ___ Stroke ___ Aneurysm ___ Hemorrhage ___
Other _____
What part of your 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)? _____
Did you lose consciousness? Yes ___ No ___ If yes, How long? _____
Were you in a coma? Yes ___ No ___ If yes, How long? _____
SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)
Double Vison ___ Headache ___ Blurred vision ___ Pain in or around eyes ___ Dizziness ___ Vomiting ___
Flashes of light ___ Disorientation ___ Loss of balance ___ Neck pain/whiplash ___ Loss of memory ___
Restricted field of view ___ Restricted motion ___ 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 at the current time: _____
_____

Do you have a history of allergies? Yes ___ No ___

If yes, please explain: _____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply):

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 Physicians Name: _____ *Date:* _____
Results and recommendations: _____
Occupational Therapist Name: _____ *Date:* _____
Results and recommendations: _____
Other/Name: _____ *Date:* _____
Results and recommendations: _____

Has a neurological evaluation been performed? Yes ___ No ___
If yes, by whom? _____ *Date:* _____
Results: _____
Has a psychological evaluation been performed? Yes ___ No ___
If yes, by whom? _____ *Date:* _____
Results: _____
Has a speech and language evaluation been performed? Yes ___ No ___
If yes, by whom? _____ *Date:* _____
Results: _____

MEDICAL HISTORY

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

	Patient	***Family***	***Relationship***
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid condition	_____	_____	_____
Multiple Sclerosis	_____	_____	_____
Brain Tumor	_____	_____	_____
Stroke	_____	_____	_____
Glaucoma	_____	_____	_____
Cataracts	_____	_____	_____
Blindness	_____	_____	_____
Strabismus	_____	_____	_____
Amblyopia	_____	_____	_____
Traumatic Brain Injury	_____		

VISUAL HISTORY

Have you had a previous vision evaluation? Yes___ No___

If yes, doctor's name: _____ *Date:* _____

Reason for examination: _____

Were glasses, contact lenses or other optical devices recommended? Yes___ No____

If yes, what? _____

Are they used? Yes___ No___ If yes, when? _____

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes___ No___

If yes, what? _____

Did you undergo these treatments? Yes___ No___ Explain _____

Results and recommendations: _____

DO YOU 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	_____	_____	_____
Light Sensitivity	_____	_____	_____
Motion sickness/car sickness	_____	_____	_____
Headaches	_____	_____	_____
Blurred vision	_____	_____	_____
Difficulty changing focus far to near	_____	_____	_____
Double vision	_____	_____	_____

	YES	NO	PRIOR TO INJURY
One eye turns in, out, up or down			
Movement of objects in the environment is bothersome			
Fluorescent light is bothersome			
Patterned wallpaper or carpet is 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			
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 formerly easy/routine			
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 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 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?

_____

_____

_____

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? _____

"I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF D. TODD WYLIE O.D.'S NOTICE OF PRIVACY PRACTICES. I AM AWARE A COPY OF THIS IS AVAILABLE TO ME UPON REQUEST"

NAME: _____ ***DATE:*** _____

ADVANCED EYECARE & THERAPIES

D. TODD WYLIE, OD, FCOVD

104 S FREYA ST, SUITE 220
WHITE FLAG BUILDING
SPOKANE, WA 99202-4867
509-535-5855
Fax: 509-535-3916

PATIENT FINANCIAL RESPONSIBILITY

It is the policy of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
- Please pay your co-payment at time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- Please double check with your insurance plan as to the participation status of the physician you are seeing.

You should receive a bill for any patient responsibility within 30 days: and/or an explanation of benefits from your insurance carrier. If you do not, please contact the billing office at 509-535-5855

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued.

Payment options if you have insurance: We are required by our insurance contracts to collect all co-payments at the time of service.

Payment options if you have no insurance: For your convenience we accept cash, check or credit card on the day treatment is provided.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to the appointment date.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

Divorced Parents: In case of divorce or separation the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree required the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Returned checks: There is a fee (currently $35.00) for any checks returned by the bank for insufficient funds.

Waiver of confidentiality: You understand if the account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Having read the above financial information, I request the services be performed. I also agree to be ultimately responsible for charges incurred for myself or my child/children as their legal parent or guardian.

_____ _____

Signature of patient (or Patient's authorized representative) Patient's Name (Print)

_____ _____

Authorized Representative's Relationship to Patient Date Time

Driving directions to Advanced Eyecare Center

D.Todd Wylie OD
104 S Freya St, Suite 220
WHITE Flag Building
Spokane WA 99202-4867

Phone: (509)535-5855

Approaching from EAST:

- On I-90 westbound: Take Thor/Freys exit (283B) and proceed on 2nd Ave just past light at Freya. Turn right into second driveway w/large blue TAPIO sign
- On Sprague westbound: Turn left at Freya and proceed in left lane and turn left into driveway at blue TAPIO sign.

Approaching from SOUTH:

- From South Hill- take Ray to 2nd Ave. Turn left onto 2nd and then turn right into second driveway w/large blue TAPIO sign
- From US-195 northbound: Merge with I-90 East. Go to Thor/Freya exit (283B) and proceed to Freya, turn left; left again onto 2nd Ave. Turn right into TAPIO driveway.

Approaching from WEST:

- From I-90 Eastbound: take Thor/Freya exit (283B) and proceed to Freya, turn left and turn left again onto 2nd Ave. Then turn right into TAPIO driveway.
- On Sprague eastbound: Turn right onto Freya at light. Be in left hand lane and turn left into driveway that has large blue TAPIO sign.

Approaching from NORTH:

- From Market southbound: follow as it changes to Greene St then Freya. After light at Sprague continue and turn left into driveway at blue TAPIO sign.
- From US 395 southbound: Take new North Spokane Corridor to Freya, then west on Francis to Market. Turn south on Market and follow preceding directions.
- From Northwest Spokane areas: Take Maple, Division or Hamilton to Mission and turn left on Mission. Go to Greene St. turn right and go southbound on Greene/Freya past Sprague and turn left into driveway at large blue TAPIO sign.