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InDepth Vision
VISION THERAPY AND REHABILITATION

BRAIN INJURY VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at least 48 hours prior to your appointment. Thank you.

Patient's full name: _____ Date of Birth: _____
Address: _____ Phone number: _____
_____ Email: _____
Parent/Caregiver name(s): _____
Health Card Number: _____ Version Code: _____ Expiry: _____
Credit Card Number: _____ Expiry: _____ Security Code: _____
Name on Credit Card: _____ Billing Address: _____
Were you referred to our clinic? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _____

MEDICAL HISTORY

Family Doctor: _____ Family Doctor Phone Number: _____
Allergies: _____
Medical conditions: _____
_____
Medications (incl. vitamins/supplements): _____
_____
Do any eye diseases run in the family? _____
_____

VISUAL HISTORY

Main reason for having an examination today? _____
_____
_____
Date of last eye exam: _____ Optometrist: _____
Please describe any previous eye or vision problems and treatment you have received (including glasses, vision therapy, patching, surgery, medications, etc.): _____
_____
_____

Do you wear any of the following: (Please check all that apply)

- ☐ Distance glasses
- ☐ Progressive glasses
- ☐ Sunglasses
- ☐ Reading glasses
- ☐ Bifocal/Trifocal glasses
- ☐ Contact lenses (brand: _____)

When did you begin wearing glasses? _____

Do you feel your glasses/contact lenses are working well for you? ☐ Yes ☐ No

BRAIN INJURY INFORMATION

Please note: If you do not like to discuss your brain injury, please feel free to not complete any of the following questions

Date of brain injury: _____

Any previous brain injuries? ☐ Yes ☐ No

If yes, dates of previous brain injuries: _____

How did you sustain your brain injury? (please check all that apply)

- ☐ Motor Vehicle Accident (MVA) →
- ☐ Sports related
- ☐ Work-place accident
- ☐ Other accident (i.e. fall, hit to the head, etc.)
- ☐ Toxic (i.e. medication, drug abuse, poison, etc.)
- ☐ Anoxic (i.e. near drowning, umbilical cord around neck, etc.)
- ☐ Vascular (i.e. stroke, aneurysm, hemorrhage, etc.)
- ☐ Other

If you were involved in a MVA:

Type of vehicle (i.e. car, truck, etc.):

If other vehicle(s) involved, list type(s):

Approx. speed of vehicle you were in:

Approx. speed of other vehicle:

Where were you sitting?

- ☐ Driver's seat
- ☐ Passenger seat (front)
- ☐ Passenger seat (behind driver)
- ☐ Passenger seat (behind front passenger)
- ☐ Other: _____

Did you experience whiplash? ☐ Yes ☐ No

Did you hit your head? ☐ Yes ☐ No

If yes, what part of your head? _____

Did you lose consciousness? ☐ Yes ☐ No

If yes, for how long? _____

Describe the accident/trauma? _____

Did you go to the hospital/see a doctor concerning the accident/trauma? ☐ Yes ☐ No

Whom did you see, and where? _____ When? _____

What were you or your family told? _____

Was an MRI or CT scan done? ☐ Yes ☐ No Results of scan: _____

What type of professional care for your injury/trauma have you received or are receiving (i.e. osteopath, physiotherapist, occupational therapist, psychologist, neurologist, etc? _____

Is there anything else that you feel is relevant that you would like to share? _____

SUBSEQUENT SYMPTOMS

For each of the symptoms listed below please place an 'x' in the column that applies.

Symptom	Present prior to injury and is the same	Present prior to injury and has worsened	New since injury
Blurred vision at distance	☐	☐	☐
Blurred vision at near	☐	☐	☐
Slow to shift focus (near to far, far to near)	☐	☐	☐
Difficulty tracking an object or moving eyes	☐	☐	☐
Burning, itching or tearing eyes	☐	☐	☐
Double vision	☐	☐	☐
Reduced depth perception/3D vision	☐	☐	☐
Light sensitivity	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Wandering or crossed eye	☐	☐	☐
Covering/closing one eye	☐	☐	☐
Squinting	☐	☐	☐
Pain and/or pulling or tugging sensation around eyes	☐	☐	☐
Flashes of light and/or floaters in field of view	☐	☐	☐
Restricted field of vision and/or tunnel vision	☐	☐	☐
"Curtain" billowing into field of view	☐	☐	☐
Discomfort while reading	☐	☐	☐
Unable to sustain near work/reading for adequate periods of time	☐	☐	☐
Eyes get tired while reading	☐	☐	☐
Avoids reading	☐	☐	☐
Difficulty with remembering what has been read	☐	☐	☐
Poor reading comprehension	☐	☐	☐
Loses place when reading	☐	☐	☐
Skips, re-reads or omits words/lines	☐	☐	☐
Uses finger to track when reading	☐	☐	☐
Vocalizes when reading	☐	☐	☐
Words moving or running together	☐	☐	☐
Abnormal general fatigue	☐	☐	☐
Headaches	☐	☐	☐
Dizziness	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐
Difficulty with memory	☐	☐	☐
Decreased concentration, attention span and/or easily distracted	☐	☐	☐
Motion/car sickness	☐	☐	☐
Bothered by movement around you	☐	☐	☐

Head tilt and/or face turn	☐	☐	☐
Poor coordination and/or poor hand-eye coordination	☐	☐	☐
Clumsiness and/or loss of balance	☐	☐	☐
Disorientation or feeling lost in space	☐	☐	☐
Difficulty taking notes/poor handwriting	☐	☐	☐
Frequent letter, number or word reversals	☐	☐	☐
Difficulty in busy environments (i.e. malls, grocery stores)	☐	☐	☐
Confuses left & right	☐	☐	☐

Other symptoms not listed: _____

_____

_____

OCCUPATION

Occupation: _____ Employer: _____

Percentage of your day spent on electronics (i.e. computer, phone, etc): _____

Are you currently working? ☐ Yes ☐ No

If no, have you been off since your brain injury? ☐ Yes ☐ No

have you attempted to return to work? ☐ Yes ☐ No

FURTHER INFORMATION

Is there anything else you would like to tell us? _____

_____

_____

_____

_____

_____

_____

_____

PLEASE BRING YOUR CURRENT GLASSES AND SUNGLASSES TO YOUR EXAM

Thank you. We look forward to seeing you at the office!