EyeCare Associates, P.C.
TBI Intake Form

General Information

Full Name:_____ Nickname:_____
Address: _____ City _____State_____ Zip_____
Telephone:_____ Phone Type: _____ Birthdate:_____/_____/_____
Spouse's Name:_____ Other family members at home (include ages and relationship):
_____
Insurance Carrier:_____ Policy#:_____
Referred By:_____ Phone Number: _____

General Health

Past illnesses and injuries (include what age and how severe): _____
_____
Medications used prior to accident:_____

Current Accident History

Description of Accident:_____
_____
Date:_____ Most Recent Medical Exam:_____
Diagnosis:_____
_____
Doctor's Name:_____ Phone #:_____
Health at present: Good_____Fair_____Poor_____
Has a Neurological/Psychological Evaluation been performed? Results?_____
_____
Specific areas of the brain tissue affected:_____
Medications currently being used:_____
Surgeries performed and dates:_____
Length of coma (if applicable):_____

Current Therapies

Please list the current therapies you are involved in:

1.	Primary Goal:
2.	Primary Goal:
3.	Primary Goal:

Prior Occupational History

Position before accident:_____
Prior to the accident, were there any difficulties in school?_____
_____
Prior to the accident, could you learn from reading?_____
Prior to the accident, what schools did you graduate from and in what year?_____
_____
Prior to the accident, what were your educational and occupational goals?_____
_____

(Please continue to the next page)

Avocations and Interests

Describe what activities comprise the majority of your spare time:_____

_____

What activities would you like to become interested in?_____

What type of exercise do you do, and how often? _____

Visual History before Trauma

Vision Symptoms prior to the accident:_____

Vision exams prior to the accident (Y/N and type of exam):_____

Doctor's Name:_____ Date:_____

Reason for Exam:_____

Did you wear glasses prior to the accident?_____ Contact Lenses?_____ How long?_____

Eye Surgeries prior to the accident?_____

Visual Problems after Trauma

Please circle all that apply:

Appearance of Eyes: ● One eye turns in/out ● Covering or closing one eye, or squinting ● Eyes appear red or tear excessively ● Frequent rubbing/blinking/squinting of eyes ● General or visual fatigue at the end of the day ● Inability to completely close eyes	Visual Perception: ● Fails to visualize what is read ● Whispers to self while reading ● Objects appear closer or further than they really are ● Poor navigation ● Loss of peripheral vision ● Confusion about what is being read ● Reduced visual memory
Complaints when using Eyes: ● Flashes of light / floaters in field of view ● "Curtains" billowing into field of view ● Burning/itching/pain in eyes after reading or work ● Slow shift of focus from far to near ● Pulling/tugging sensation around eyes ● Pain or difficulty moving or turning eyes ● "Wandering" eyes	Focusing: ● Holds book too closely ● Difficulty sustaining near point tasks ● Complains of discomfort in tasks that demand visual attention ● Makes errors when copying distance to near ● Reduced sharpness of vision at distance or near
Behavioral Signs of Visual Problems: ● Skipping lines when reading ● Misaligns digits in columns ● Head movement or tilt when reading ● Uses finger or marker to keep place ● Omission of words when reading/copying material ● Slow reading speed ● Letters or words appear to float around	Disorientation: ● Poor posture ● Sensation of the floor/ceiling/walls being tilted ● Sensation of the room spinning ● Sensation of not feeling grounded ● Postural shifts/veering off when reading ● Nausea or dizziness ● Headaches

Any other visual symptoms not listed above:_____

_____

_____

Comments on any items circled above:_____

_____

_____

(Please continue to the next page)

Persistent Post-Trauma Vision Syndrome

Patient_____ Age_____ Date of Injury_____

Symptom	Initial Subjective Score Date: _____	Post: Subjective Score Date: _____
	Initial Score	Progress Report Score
☐ Headaches	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Photophobia	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Phonophobia	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Tactile defensiveness	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Mental/physical fatigue	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Decreased Attention	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Irritability	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Distress/anxiety	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Balance issues	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Vertigo/Nausea	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Sleep disturbances	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Disordered thinking	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Emotionally sensitive	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Blurred vision	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Motion Smearing or Color sliding	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10
☐ Tinnitus	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Word difficulties	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Avoids/intolerant of work	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Overwhelmed in busy sound or visual environments	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Pulls away from looming objects	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Upset by objects moving nearby	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Staring behavior (low blink rate); zoning out	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Loses track of "place"	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Losing place when reading	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Movement of text (*Textual Visual Aliasing*)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Comprehension problems reading	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Memory problems	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Double vision.		
	Total Score/Avg. _____	Total Score/Avg. _____
	Symptoms over Median ____	Symptoms over Median ____

NOTES: