LONG ISLAND OPTOMETRIC VISION DEVELOPMENT, PLLC

DEVELOPMENTAL OPTOMETRISTS

Dr. Michele R. Bessler
Dr. Shoshana Craig

300 Garden City Plaza, Suite 234
Garden City, New York 11530
Phone: 516-334- 9385

Vision Rehabilitation Evaluation History Form

Appointment Dates/Times: First Visit:_____ Second Visit:_____ Conference:_____

Patient's First Name:_____ Patient's Last Name:_____
Patient's Nickname: _____ Date of Birth: _____Age:_____
Home Address:_____ City: _____Zip:_____
Patient's Telephone: Home: ( )_____ Cell: ( )_____ Work: _____
Patient's Occupation: _____ Email Address: _____@_____
Social Security#_____

Spouse's First Name:_____ Spouse's Last Name:_____
Spouse's Telephone: Home: ( ) _____Cell: ( ) _____ Work: _____
Spouse's Occupation: _____Email Address: _____@_____
Names and ages of children:
_____ _____
_____ _____

Who may we thank for referring you? _____ Profession: _____
Address: _____ Phone: _____

ACCOUNT RESPONSIBLE INFORMATION

Person responsible for payment: Self ( ) Spouse ( ) Other ( )_____

Do You Have **Major Medical** Insurance? Yes ( ) No ( ) Company:_____
Insurance Address:_____ Insurance Phone:_____
Subscriber Name:_____ DOB:_____ SSN:_____
Subscriber ID#:_____ Group#:_____

Do You Have A **Vision** Insurance Plan? Yes ( ) No ( ) Company:_____
Insurance Address:_____ Insurance Phone:_____
Subscriber Name:_____ DOB: _____ SSN:_____
Subscriber ID#:_____ Group #:_____

PLEASE REMEMBER TO BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT.
Please read and sign the statement below:
I understand that payment is expected when services are rendered.
I will paying today by: cash_____ check_____ credit card_____

Signature:_____ Date: _____

VISION HISTORY

Last Vision Examination Date: _____ Name of Doctor/Address:_____

Recommendations advised at that time: _____

Please check all that apply:

- ☐ I wear glasses only for reading
- ☐ I wear glasses for distance, and remove them for reading
- ☐ I wear glasses full-time
- ☐ I do not use glasses currently for anything
- ☐ I wear contact lenses
- ☐ I use specialized magnifiers/optical devices
- ☐ I use prescription eye drops; please note name of drops and frequency of use: _____
- ☐ I use over-the-counter eye drops; please note name and frequency of use: _____

Has any other professional evaluation found evidence indicating a vision problem is present? ( ) Y ( ) N

If Yes, what? (ie: neurological evaluation, vision exam, occupational therapy evaluation) _____

_____

Do you experience any of the following symptoms?	No	Yes	If yes, when?
Blurred distance vision	☐	☐	_____
Blurred vision at near	☐	☐	_____
Eyestrain or visual fatigue	☐	☐	_____
Headaches	☐	☐	_____
Sensitivity to sunlight or bright lights	☐	☐	_____
Double vision in the distance	☐	☐	_____
Double vision when reading	☐	☐	_____
Words split or move on the page	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel like they are pulling	☐	☐	_____
Car sickness/Motion sickness	☐	☐	_____
Covers or closes one eye when reading	☐	☐	_____
Loses place along lines when reading	☐	☐	_____
Moves head when reading	☐	☐	_____
Eye appears to turn inward/outward	☐	☐	_____
Reads very slowly	☐	☐	_____
Frequently blinks or rubs eyes with near work	☐	☐	_____
Difficulty sustaining attention when reading	☐	☐	_____
Difficulty understanding reading material	☐	☐	_____
Avoids reading, used to read a lot more	☐	☐	_____
Cannot use the computer	☐	☐	_____
Poor depth judgements with daily tasks	☐	☐	_____
Poorly organized handwriting	☐	☐	_____
Clumsy, bumps into things often in environment	☐	☐	_____
Poor eye-hand coordination	☐	☐	_____
Difficulty remembering where I put things	☐	☐	_____
Overwhelmed visually when in supermarket/store shelves	☐	☐	_____
Difficulty seeing in my peripheral vision	☐	☐	_____
Difficulty seeing on my right or left side	☐	☐	_____
Difficulty shifting my focus from near to far	☐	☐	_____
Perceive movement of stationary objects	☐	☐	_____
Very hesitant when walking	☐	☐	_____
Unstable balance/I must have assistance with walking	☐	☐	_____
Staring behaviors	☐	☐	_____
Dry or irritated eyes	☐	☐	_____
Flourescent lights are very bothersome	☐	☐	_____
Patterned wallpaper or carpet is difficult to look at	☐	☐	_____

Have you ever had:	No	Yes	When/with whom?
Eye surgery	☐	☐	_____
Eye patching	☐	☐	_____
Eye Injury	☐	☐	_____
Vision therapy	☐	☐	_____

MEDICAL HEALTH HISTORY

Please describe the nature of the traumatic brain injury that was sustained: _____

_____

On what date did the brain injury occur? _____

Were you in a coma? No ☐ Yes ☐

Do you have/use any of the following?

	No	Yes	Please describe below
Vitamins/supplements	☐	☐	_____
Allergies to medications	☐	☐	_____
Allergies to foods	☐	☐	_____
Seasonal allergies	☐	☐	_____
Anxiety/depression/fears	☐	☐	_____
Emotional concerns in the family	☐	☐	_____
Medications: (Please list all below)	☐	☐	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Internist's Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Have you ever been evaluated by the following professionals?

Neurologist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Psychologist/Neuropsychologist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Occupational Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Speech Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Physical Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Other ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Have you or a family member ever been treated for any condition relating to:

	Patient	Family	Whom?		Patient	Family	Whom?
Eyes	☐	☐	_____	Neurological	☐	☐	_____
Ears/Nose/Throat	☐	☐	_____	Endocrine	☐	☐	_____
Cardiovascular	☐	☐	_____	Genitourinary	☐	☐	_____
Respiratory	☐	☐	_____	Skin	☐	☐	_____
Gastrointestinal	☐	☐	_____	Musculoskeletal	☐	☐	_____
Psychiatric	☐	☐	_____	Hematologic	☐	☐	_____
Other	☐	☐	_____				

Do you or family member have any of the following?

	Patient	Family	Whom?		Patient	Family	Whom?
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____
High Blood Pressure	☐	☐	_____	Macula Degeneration	☐	☐	_____
Thyroid Disease	☐	☐	_____	Cataracts	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Crossed or wall eyes	☐	☐	_____
Genetic Abnormalities	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____	Dyslexia	☐	☐	_____
Cancer	☐	☐	_____	Learning Disability	☐	☐	_____

What services are you <u>currently</u> receiving? Please check all that apply:

Occupational Therapy:	No	☐	Yes	☐	No. times per week: _____
Physical Therapy:	No	☐	Yes	☐	No. times per week: _____
Speech Therapy:	No	☐	Yes	☐	No. times per week: _____
Cognitive Therapy:	No	☐	Yes	☐	No. times per week: _____
\ Counseling:	No	☐	Yes	☐	No. times per week: _____

Other: Please describe: _____

LIFESTYLE / SOCIAL HISTORY	No	Yes	
Are you currently working?	☐	☐	How often?_____
Are you currently a student?	☐	☐	Where? _____
Do you smoke?	☐	☐	How often? _____
Do you drink alcohol?	☐	☐	How often? _____
Do you exercise?	☐	☐	How often? _____

Is there anything else you would like to comment on regarding your injury or recovery process?

_____

_____

FINANCIAL POLICY:

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide you with a receipt for reimbursement submission. Any copayments are required at the time of service.

We are participating providers with: Blue Cross Blue Shield, Aetna US Healthcare and Medicare. By signing below you authorize the release of any medical information to process your insurance claims. You also allow your payment from insurance to be sent directly to Long Island Optometric Vision Development, PLLC.

Please sign that you understand the above:

Signed: _____ Date: _____

Quality of Life Symptom Checklist-TBI

Today's Date: _____ Person Filling out form: _____
Patient Name: _____ Date of Birth: __/__/___

Please circle how often each symptom occurs based on the given scale:

0 = Never or Non-existent
1= Seldom
2= Occasionally
3= Frequently
4= Always

1	Experiences blurred vision at near	0 1 2 3 4
2	Experiences double vision at distance	0 1 2 3 4
3	Experiences double vision at near	0 1 2 3 4
4	Words run together when reading	0 1 2 3 4
5	Burning, stinging, watery eyes or rubs eyes often	0 1 2 3 4
6	Falls asleep when reading or loses interest easily when reading	0 1 2 3 4
7	Note that vision is worse at the end of the day	0 1 2 3 4
8	Skips or repeats lines when reading, loses place	0 1 2 3 4
9	Dizziness or nausea associated with near work	0 1 2 3 4
10	Tilts head or closes one eye when reading	0 1 2 3 4
11	Experiences headaches associated with near work or end of day	0 1 2 3 4
12	Experiences eyestrain and eye fatigue with reading or computers	0 1 2 3 4
13	Omits small words when reading	0 1 2 3 4
14	Writes uphill, downhill, or off- line; poorly organized writing	0 1 2 3 4

15	Mis-aligns digits in columns of numbers	0 1 2 3 4
16	Reading comprehension is poor or declines over time	0 1 2 3 4
17	Difficulty concentrating when reading	0 1 2 3 4
18	Poor balance or dizziness when walking	0 1 2 3 4
19	Poor depth judgements	0 1 2 3 4
20	Poor eye-hand coordination	0 1 2 3 4
21	Tendency to knock things over on desk or table; appears clumsy	0 1 2 3 4
22	I must hold on to someone or use a cane when walking	0 1 2 3 4
23	Difficulty remembering where I put things	0 1 2 3 4
24	Difficulty finding things on a shelf, in refrigerator, etc.	0 1 2 3 4
25	Difficulty seeing on my right side or left side	0 1 2 3 4
26	Difficulty remembering what I read	0 1 2 3 4
27	Avoids reading	0 1 2 3 4
28	Avoids writing	0 1 2 3 4
29	Car sickness / motion sickness	0 1 2 3 4
30	Difficulty with time management	0 1 2 3 4