Thompson Optometry

Adult Information

If you are a healthcare professional and would like to refer your patient for Vision Therapy to our clinic for Vision Therapy, please complete the intake form below and email to **vtadmin@thompsonoptometry.ca** or print completed form and fax to **(905) 793-8528**. Please allow 48 business hours to process referrals.

Patient Full Name:			
Patient Address:			
City:		**Postal Code:**	
Cell Phone:		**Gender:**	◯ **M** ◯ **F**
Email:			
OHIP #:		**Version Code:**	
Date of Birth:	MM / DD / YYYY	**Date of MVA:**	MM / DD / YYYY
When was your last exam?		**Who was the Eye Doctor?**	

Chief Complaint (Reason for your Visit)

_____

_____

_____

_____

_____

_____

_____

Your Eye History:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Colour blindness
- ☐ Turned or wandering eye
- ☐ Eye surgery
- ☐ Dry eye
- ☐ Lazy eye
- ☐ Vision therapy
- ☐ Eye injury

Do You Currently Have:

- ☐ Trouble seeing distance
- ☐ Trouble reading
- ☐ Blur
- ☐ Headaches
- ☐ Achy eyes
- ☐ Light sensitivity
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Watering eyes
- ☐ Itchy eyes
- ☐ Tired eyes
- ☐ Burning eyes
- ☐ Double vision
- ☐ Flashes
- ☐ Spots
- ☐ Discharge from eye
- ☐ Nausea
- ☐ Dizziness

Your Medical History:

- ☐ Diabetes
- ☐ Stroke
- ☐ Head injury
- ☐ Whiplash
- ☐ Asthma

Do You Use:

- ☐ Eye drops
- ☐ Eye Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Hot compresses

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- ☐ Arthritis
- ☐ Thyroid
- ☐ Heart problems
- ☐ High blood pressure

- ☐ Eye patch
- ☐ Magnifier

- ☐ Trouble losing belongings
- ☐ Poor memory/forgetful
- ☐ Easily distracted

Head injury/stroke/other:

- ☐ Date of loss _____
- ☐ Car accident
- ☐ Stroke
- ☐ Concussion
- ☐ Other

Tests/Treatments:

- ☐ CT scan
- ☐ MRI
- ☐ Physiotherapy
- ☐ Craniosacral therapy
- ☐ Chiropractic
- ☐ Hospitalization
- ☐ Other

List of Medication:

_____
_____
_____
_____
_____

List of Allergies:

_____
_____
_____
_____
_____

Eye-Hand Coordination:

- ☐ Poor handwriting
- ☐ Difficulty reaching for objects
- ☐ Reverses/ omits letters
- ☐ Difficulty catching balls

Driving:

- ☐ Do not drive
- ☐ Valid driver's license
- ☐ License is now suspended
- ☐ Trouble judging distances
- ☐ Blur Headache
- ☐ Eye strain

Lighting and Glare:

- ☐ Sensitivity in sun
- ☐ Sensitivity on cloudy days
- ☐ Sensitivity in office/stores
- ☐ Sensitivity in home
- ☐ Sensitivity at night
- ☐ Other

TV/ Distance Vision:

- ☐ Blur
- ☐ Double
- ☐ Eye strain
- ☐ Too bright
- ☐ Squinting
- ☐ Trouble judging distances
- ☐ Other

Lighting and Glare:

- ☐ Sensitivity in sun
- ☐ Sensitivity on cloudy days
- ☐ Sensitivity in office/stores
- ☐ Sensitivity in home
- ☐ Sensitivity at night
- ☐ Other

Reading:

- ☐ Lose place
- ☐ Skip or re-reading lines
- ☐ Holds book close
- ☐ Print swims or moves
- ☐ Eye strain
- ☐ Poor comprehension
- ☐ Forgets what is just read
- ☐ Other

_____

Working/Work:

- ☐ **Do not go to school**
- ☐ **In school. Please explain any difficulties**_____
  _____
  _____

Working/Work:

Explain why you cannot work and please explain work done before the loss and after the loss. Include when or if you expect to return to work.

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_____ _____	_____ _____	Where do you work? _____

Primary Insurance Information	
Company:	
Plan Member:	
Policy:	
Member I.D:	

Secondary Insurance Information	
Company:	
Plan Member:	
Policy:	
Member I.D:	