Thompson Optometry

Head Injury/ ABI Patient Information

If you are a healthcare professional or a lawyers office and would like to refer your patient 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:**	
Patient Phone:		**Gender:**	◯ **M** ◯ **F**
Email:			
OHIP #:		**Version Code:**	
Date of Birth:	MM / DD / YYYY	**Date of Head Injury/ ABI:**	MM / DD / YYYY
When was your last eye exam?		**Who is your family Optometrist?**	
How did you hear about us?			

Health History

Family Doctor:		
Any Hospitalizations:		
List of Medications:		
Do you have any allergies?	☐ No	☐ Yes. If so, please list them here: _____ _____ _____

Please check the boxes if you have any history of the following:

☐ Glaucoma	☐ Diabetes	☐ Heart Problems
☐ Cataracts	☐ Stroke	☐ Thyroid Condition
☐ Retinal Detachment	☐ Asthma	☐ Allergies
☐ Macular Degeneration	☐ Artritis	High Blood Pressure
☐ Colour Blindness		

Do any of the listed items above run in your family? If so, please list them here:

_____

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Vision/ MVA Related Questions

Is this your first visual examination?

☐ Yes
☐ No

If not, when was your last examination?

MM / DD / YYYY

Have you had any eye injuries in the past?

☐ Yes
☐ No

If so, please explain:

_____

Have you had any eye surgeries?

☐ Yes
☐ No

If so, please explain:

_____

Please check the box if you have experienced any of the following at the time of the MVA/ABI:

☐ Eye Injury
☐ Closed Head Injury
☐ Whiplash
☐ Unconscious
☐ Physiotherapy
☐ CT Scan
☐ MRI
☐ Cranial Sacral Therapy
☐ Chiropractic Therapy

Please check the box if you get overwhelmed or anxious in any of the following situations:

☐ Big Box Stores
☐ In large groups/ crowds
☐ Driving
☐ Public transit
☐ Around loud noises

Do you currently have a valid driver's license?

☐ Yes
☐ No

Has your driver's license ever been suspended?

☐ Yes
☐ No

Do you work currently (part time or full time)?

☐ Yes
☐ No

If not, what barriers prevent you from working?

_____
_____
_____

Visual Signs & Symptoms (Physical)

Please check the boxes if you have any history of the following:

- ☐ Dry Eyes
- ☐ Burning Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Rubbing Eyes
- ☐ Squinting
- ☐ Eye Drops
- ☐ Eye Turn
- ☐ Wandering Eye
- ☐ Eye Pain
- ☐ Flashes/Spot in Vision

Reading

Average reading time prior to the MVA/ABI? _____

Average reading time after the MVA/ABI? _____

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Lose place while reading
  Skip or re-read lines
- ☐ Falls asleep reading
- ☐ Blur reading
- ☐ Double vision reading
- ☐ Shuts one eye to read
- ☐ Trouble comprehending things you read
- ☐ Hold closely to read
- ☐ Print moves/jump
- ☐ Eye strain
- ☐ Headaches
- ☐ Dizziness
- ☐ Nausea

Hand-Eye Coordination

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

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

Distance Vision

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Eye strain
- ☐ Blur Distance
- ☐ Vehicles appear in wrong lane
- ☐ Double vision distance
- ☐ Trouble judging distance

Lighting

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Light sensitivity indoors
- ☐ Light sensitivity in sunlight
- ☐ Trouble seeing in dark areas
- ☐ Glare of lights at night
- ☐ Light induced headache

Walking

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Bumps into things/people
- ☐ Dizziness while moving
- ☐ Lose balance while walking
- ☐ Ground does not appear level
- ☐ Need assistive device while walking (cane, walker, etc)
- ☐ Trips over objects/ curb
- ☐ Nausea while moving

Standing/ Sitting

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Feel dizzy while still
- ☐ Incomplete image of objects
- ☐ Lose balance easily
- ☐ Seeing objects or things that are not really there
- ☐ Objects move while sitting
  Nausea while sitting
- ☐ Nausea while standing

Other

Please check the box if you have experienced any of the following since the time of the MVA/ ABI:

- ☐ Loses belongings
- ☐ Easily distracted
- ☐ Poor memory/ forgetful
- ☐ Poor concentration
- ☐ Dizzy while travelling (car)
- ☐ Nausea while travelling (car)
- ☐ Trouble comprehending things you see
- ☐ Trouble comprehending what you hear

If you have any specific comments or questions for the doctor please list them here:

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