Thompson Optometry

Motor Vehicle Accident- Intake 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 MVA:**	MM / DD / YYYY

Motor Vehicle Insurance Company:			
Address:			
Phone/Fax:			
Adjuster:			
Claim Number:			
Other Insurance: (Employer; Private etc.)	**Insurance Co.**	**Policy#**	**Member I.D**

Referred By:	
Case Manager:	
OT:	
Lawyer:	
Family Optometrist:	
Other Specialists:	
Visual Symptoms Experienced:	

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Health History

Family Doctor:		
Any Hospitalizations:		
List of Medication:		
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	☐ Arthritis	☐ High Blood Pressure
☐ Colour Blindness		

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

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

Do you experience any headaches? [ ] No [ ] Yes, please explain: _____

Reading

Average reading time prior to the MVA? _____

Average reading time after the MVA? _____

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:

_____