VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Neuro-Optometric History Form

Brain Injury/Neuro History: Please briefly describe your injury/accident/diagnosis (date, time, loss of consciousness, symptoms at time of injury, etc) and/or reason for coming to our practice:

Did you have neuroimaging performed, and if so when and what type/results (e.g., CT or MRI of brain):
____

What are your main visual concerns that are bringing you in?

Of all of the things that you have had difficulty doing, what is the top 1-3 things that are the MOST important for you to return to/regain?
1) ____
2) ____
3) ____

CISS: In regards to symptoms when reading or doing close/computer work:

	Never	Rarely	Sometimes	Frequently	Always
□ Eyes feel tired	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes feel uncomfortable	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes feel sore	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes hurt	□ 0	□ 1	□ 2	□ 3	□ 4
□ Feel a “pulling” feeling around the eyes	□ 0	□ 1	□ 2	□ 3	□ 4
□ Get headaches	□ 0	□ 1	□ 2	□ 3	□ 4
□ Feel sleepy/tired	□ 0	□ 1	□ 2	□ 3	□ 4
□ Lose concentration	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have trouble remembering what you read	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have double vision	□ 0	□ 1	□ 2	□ 3	□ 4
□ Words move, jump, swim, or float on the page	□ 0	□ 1	□ 2	□ 3	□ 4
□ Read slowly	□ 0	□ 1	□ 2	□ 3	□ 4
□ Words blur or come in and out of focus	□ 0	□ 1	□ 2	□ 3	□ 4
□ Lose your place	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have to re-read the same line of words	□ 0	□ 1	□ 2	□ 3	□ 4

VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Your Vision Symptoms: Please mark (x) each symptom you have experienced in the last 4 weeks or since your injury.

Category	Symptoms
Visual Clarity	□ Blurry vision at distance with head stable □ Blurry vision at distance with head moving □ Blurry vision at near □ Blurry vision fluctuates throughout the day □ Reduced vision at night
Double Vision	□ Double vision is horizontal – two images side by side □ Double vision is vertical – two images up and down □ Double vision is at distance □ Double vision is at near
Visual Tasks Provoke Physical Symptoms of	□ Headaches □ Dizziness □ Nausea □ Brain fog – confusion, disorientation □ Fatigue □ Eye pain □ Eye strain
Light Sensitivity to	□ Normal indoor lighting □ Fluorescent indoor lighting □ Outdoor sunlight □ Electronics/screens □ Flashing/strobing/flickering lights
Dry Eye Symptoms	□ Vision/light sensitivity worse in the morning □ Vision/light sensitivity worse in the afternoon □ Eyes sting/burn/feel dry □ Eyes are red □ Eyes water
Depth Perception	□ Clumsiness/misjudge where objects really are in space □ Lack of confidence walking, missing steps, stumbling □ Poor Handwriting (spacing, size, legibility)
Peripheral vision	□ Side vision is distorted/objects move or change position □ Missing piece/part of peripheral vision □ Difficulty with visual motion □ Carsickness □ Flashes of light □ Floaters
Visual Processing	□ Anxiety in visually crowded areas (restaurants, grocery stores) □ Difficulty with visual search tasks (ex: can't find the milk in the fridge) □ Difficulty concentrating on a task □ Poor ability to organize work □ Confusion following a series of verbal instructions □ Confusion following a series of written instructions □ Confusion with directional orientation/maps/planning in space □ Difficulty with memory

Other symptoms not listed above: ____

____

VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Vision Quality of Life with Time Survey (VisQuaL-T)

Please fill out if any of the following activities below give you symptoms, and if so, how long it takes before they begin. Symptoms include headache, dizziness, eye strain, double vision, floating words, blurry vision, inability to pay attention, easily distracted, or sleepy/drowsy. If you do not perform a specific activity and it is not applicable to you, select N/A. If you never experience any of the symptom listed above for the specific activity, select 60+ min. *Note: If you select more than four N/A's, fill out one Optional Additional Activity for each N/A's above four. For example, if you selected 6 N/A's, fill out two of the Optional Additional Activities. In the Optional Activities, fill out an activity you perform regularly that is more applicable to you.*

Activities Important to You	0 – 15 min	15 – 30 min	30 – 45 min	60+ min	N/A
Read for pleasure?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Study for a test / examination?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Complete homework?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Complete work in an office setting? (i.e. reading / writing / typing reports)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Be in crowded locations? (i.e. malls, train station, airports, meetings, busy walkways, etc.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Tolerate habitual lighting in a classroom or workplace?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Use a smartphone / tablet?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Play a computer / console video game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Use a computer or laptop for general purposes? (i.e. email, Facebook, etc.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Watch a show / movie on a screen larger than 9"? (iPad Pro or larger)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Additional Activity 1: ______________________	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Additional Activity 2:______________________	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4