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B E Y O N D T R A D I T I O N A L V I S I O N C A R E

IMPORTANT: The information on this intake form will enable the doctor to ascertain and evaluate your needs most effectively. Please fill out the following as completely as possible and plan 2 hours for the initial examination. Thank you and we look forward to meeting you!

INSTRUCTIONS: 1) You may type directly on this form in Adobe Acrobat®, and email it to us by clicking the "submit" button. OR, 2) print this form and write the information directly in the spaces provided; fax or mail the completed form to the fax number or address in the upper right-hand corner. PLEASE forward any other pertinent records to our office after this form has been submitted.

I. Patient Information

Last Name		First		Middle	Called by	
Birth Date	Month	Day	Year	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street Address						
City		State	Zip	E-mail		
Home Phone ()				Mobile Phone ()		
Work Phone ()				Who referred you to us?		

Insurance Information

Medicare or Social Security number			Case or Policy number			
Name of Insurance Company			Contact Person			
Street Address						
City		State	Zip	E-mail		
Contact Phone ()				Contact Fax ()		

Please describe the nature of your brain injury (what happened, when, symptoms, recovery, and current complaints):
 Type here:

Current Treatment (e.g. Physical Therapy, Occupational Therapy, etc.):

Case Manager	Phone ()
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Rehabilitation Facilities Attended:

Name	Dates
Name	Dates

II. Current Symptoms

	Never	Sometimes	Often	Difficulty with:	Never	Sometimes	Often
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tunnel vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maintaining attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judging space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Behavior Characteristics

	Never	Sometimes	Often		Never	Sometimes	Often
Inattentive to what others say	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Know-it-all" attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of inferiority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tense, uptight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preoccupation in your own world	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day-dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boisterous, rowdy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily led by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impertinent, saucy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacks self-confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to annoy others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacks enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires frequent naps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shy, bashful, easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity (Always on the go)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not get enough sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous, jittery, jumpy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs large amount of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (fearfulness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific fears _____				Awakens tired and slow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting, hot-tempered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular arising time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative attitudes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disoriented and confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profane language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fussy eater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular elimination habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eats large amount of sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irresponsible - undependable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eats rapidly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention-seeking (shows off)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bites nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment on any long term problems during school years or in past history (before brain trauma):

Type here:

Foods: Please list foods which are liked + foods that are avoided or disliked.

Likes

Type here:

Dislikes

Type here:

IV. Speech - Auditory History

	Yes	No		Yes	No
Is your speech clear?	<input type="checkbox"/>	<input type="checkbox"/>	Omissions of parts of words	<input type="checkbox"/>	<input type="checkbox"/>
Can you express thoughts clearly?	<input type="checkbox"/>	<input type="checkbox"/>	Stuttering	<input type="checkbox"/>	<input type="checkbox"/>
Do you turn your head to one side to listen?	<input type="checkbox"/>	<input type="checkbox"/>	Is speech understandable by others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often say "huh"?	<input type="checkbox"/>	<input type="checkbox"/>	Are there any unusual patterns of speech	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to unusual patterns of speech, please describe: _____

What other language(s) are spoken? _____

V. Visual History

Have you had any unusual visual attention or care? Yes No

Do you have glasses now? Yes No

Do you wear them? Yes No

If yes, when should you wear them? _____

Have your lenses been changed since the trauma? Yes No

How often? _____

Do you complain of:	Yes	Sometimes	No	When you read or write do you:	Yes	Sometimes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reverse letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision (far)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reverse words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision (near)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skip or repeat words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keep place with finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Move lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bright lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Move head excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lose place on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been noticing:				Close or cover one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubbing your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tilt or turn head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distort face muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive blinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have an awkward posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you maintain concentration for a long period of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting too close to the TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Any other information? (example: When and how often do these symptoms occur?)

Type here: _____

VI. Medical History Before Trauma

Diabetic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthmatic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	What are the allergies? Type here:
Epileptic	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

VII. Additional Information

Does anyone live with you? _____ Relationship _____

Guardian Name _____

Street Address [if different from yours] _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-Mail _____ Occupation or Position _____

Signature _____ Date _____

We will ask you to sign this form at your first visit.



Please print this form out using the Acrobat® print menu.
You can fax or mail it to us using the information in the upper right corner on page 1.
Thank you!

SUBMIT