TEXAS VISION THERAPY

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NEURO-OPTOMETRIC INTAKE FORM **(completed in addition to the adult or child intake form)**

Full Name: _____ Male ☐ Female ☐

Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Cell phone: _____

Email Address: _____

Are you currently employed? ☐ Yes ☐ No

If yes, what is your occupation? _____

Initial Onset of Condition (trauma, stroke, neuro-degenerative disease, etc):

Describe what happened the first time you were diagnosed or began experiencing symptoms:

_____

_____

_____

SYMPTOMS:

Check all that apply (rate severity from 1-10 in the box next to symptom; 10 being the worst)

Rate	Symptom	Rate	Symptom	Rate	Symptom	Rate	Symptom	Rate	Symptom
	Dizziness		Neck ache		Lightheadedness		Rocking / tilting		Double vision
	Nausea		Difficulty walking		Fatigue		Unsteadiness		Spinning
	Anxiety		Light sensitivity		Brain fog		Fainting		Hearing loss
	Headache		Difficulty reading		Visual changes		Falling		Other (list below)

_____

_____

HISTORY OF PRESENT ILLNESS:

When did your problem start (approximately)? _____

Was it associated with a related event (head injury, stressful situation, etc)? ☐ Yes ☐ No

If yes, please explain _____

Was the onset of your symptoms: ☐ Sudden ☐ Gradual ☐ Overnight ☐ Other

Describe: _____

Are your symptoms: ☐ Constant ☐ Variable (come and go)

If variable:

The symptoms occur ever (# of): _____ hours _____days _____weeks

_____ month ____ year

The symptoms last: ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Do you have any warning signs that spells are about to happen? ☐ Yes ☐ No

If yes, please describe: _____

Are you completely free of symptoms between spells? ☐ Yes ☐ No

Do your symptoms occur when changing positions? ☐ Yes ☐ No

If yes, check all that apply:

X	Position	X	Position	X	Position
	Rolling your body to the left		Rolling your body to the right		Sitting in a chair while it spins
	Moving from a lying to a sitting position		Looking up with your head back		Drifting when walking down the hallway
	Turning your head side to side while standing / sitting		Bending over with your head down		Other:

Is there anything that makes your symptoms better? ☐ Yes ☐ No

If yes, please explain: _____

Is there anything that makes your symptoms worse? ☐ Yes ☐ No

If yes, check all that apply:

X	Activity	X	Activity	X	Activity	X	Activity
	Moving head		Physical activity or exercise		Standing up		Eating certain foods
	Riding or driving in cars		Large crowds or busy environments		Time of day		Menstrual periods (if applicable)
	Loud sounds		Coughing, blowing the nose, straining		Stress		Scrolling on computers or phones
	Bright lights		Driving on the highway		Looking at screens		Other

When you have symptoms, do you need to support yourself to stand or walk? ☐ Yes ☐ No
If yes, how do you support yourself? _____
Have you ever fallen because of your current symptoms? ☐ Yes ☐ No

EAR-RELATED SYMPTOMS:

Do you have difficulty with hearing? ☐ Yes ☐ No
If yes, which ear(s)? ☐ Left ☐ Right ☐ Both
Do your ear symptoms occur at the same time as your dizziness/imbalance? ☐ Yes ☐ No

DIZZINESS/IMBALANCE SYMPTOMS:

When dizzy or imbalanced, do you experience any of the following?

Symptom	**Yes**	**No**
Lightheadedness or a floating sensation?		
Objects or your environment turning around you?		
A sensation that you are turning or spinning while the environment remains stable?		
Nausea or vomiting?		

When you are walking, do you: ☐ veer left? ☐ veer right? ☐ remain in a straight path?
Do you have a head tilt? ☐ Yes ☐ No
If yes, does it tilt to the: ☐ Right ☐ Left

PRIOR MEDICAL EVALUATIONS, DIAGNOSTIC TESTING, AND TREATMENT:

Have you seen other healthcare providers for your current condition? ☐ Yes ☐ No
If yes, who? _____
_____
Have you had any imaging done for your condition (MRI, CT, etc)? ☐ Yes ☐ No
If yes, please list type: _____
Have you done any rehabilitation/therapy for your condition? ☐ Yes ☐ No
If yes, please list type: _____

Social History/Lifestyle:

Do you use a computer at work or at home? ☐ Yes ☐ No
If yes, how many hours a day do you spend on the computer? _____
Do your symptoms get worse on a computer? ☐ Yes ☐ No