TEXAS VISION THERAPY

Justin Chelette, OD FAAO
Developmental Optometrist

ADULT INTAKE FORM

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Cell phone: _____
Email Address: _____
What is your occupation? _____
Employer: _____ Business Phone: _____

REASON FOR VISIT

What brings you to our office? _____
_____
_____

Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____
Phone: _____ Email Address: _____
Address: _____
If not referred, how did you learn about our office? _____
_____

Have you had a comprehensive eye examination, with dilation, to assess your ocular health?
Yes ☐ No ☐
If yes, doctor's name: _____
Date of last visit: _____
Wear glasses, contact lenses, or other optical devices prescribed or recommended?
Yes ☐ No ☐
Do you use them? Yes ☐ No ☐
If not, why? _____

YOUR MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____

Physician's Address: _____

Please list the medications you are currently using including vitamins and supplements:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____
5. _____ Condition: _____
6. _____ Condition: _____

Allergies to foods or medications. If yes, please list: _____

_____

Please list any illnesses, bad falls, high fevers or ear infections, etc.:

Age Severe Mild Complications

_____

_____

_____

If you have an eye turn, was there any related trauma, disease, or condition that preceded or accompanied its onset? Yes ☐ No ☐

If yes, please explain: _____

Has a neurological evaluation been performed? Yes ☐ No ☐

If yes, by whom? _____

Results and recommendations: _____

_____

Has a psychological evaluation been performed? Yes ☐ No ☐

If yes, by whom? _____

Results and recommendations: _____

_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

If yes, by whom? _____

Results and recommendations: _____

_____

YOUR MEDICAL HISTORY, continued

Please mark an "X" on conditions that apply

_____ Strabismus (Crossed Eyes)
_____ Amblyopia (Poor Vision)
_____ Learning Disability
_____ Dyslexia
_____ ADD/ADHD
_____ Asperger's Syndrome/Autism
_____ Epilepsy/Seizure
_____ Chromosomal Imbalance
_____ Diabetes
_____ Thyroid Condition
_____ Brain Tumor/Brain Injury/Concussion
_____ Other, please list_____

FAMILY MEDICAL HISTORY

Please mark an "X" on all applicable conditions and list the family member(s) with them?

_____ High Cholesterol - Family Member(s): _____
_____ Thyroid - Family Member(s): _____
_____ Heart Disease - Family Member(s): _____
_____ Cancer - Family Member(s): _____
_____ Diabetes - Family Member(s): _____
_____ High Blood Pressure - Family Member(s): _____
_____ Glaucoma - Family Member(s): _____
_____ Cataracts - Family Member(s): _____
_____ Macular Degeneration – Family Member(s): _____
_____ Retinal Detachment - Family Member(s): _____
_____ Strabismus (Crossed Eyes) - Family Member(s): _____
_____ Amblyopia (Poor Vision) - Family Member(s): _____
_____ Other - Family Member(s): _____

LIFESTYLE; EMPLOYMENT OR SCHOOL

How many hours a day do you spend at your desk? _____

Are your eyes fatigued at the end of the day? Yes ☐ No ☐

Do you feel you are working up to your potential at work or in school? Yes ☐ No ☐

Do you feel you are getting adequate return for the effort you put into a task?

Yes ☐ No ☐ If no, please explain: _____

_____

COMPUTERS/SCREEN USAGE

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐

If so, indicate the types of computer work you perform:

☐ Word processing ☐ Internet

☐ Programming ☐Games / Leisure activities

☐ Data entry

☐ Other (explain): _____

How many hours do you spend in front of a computer/device screen each day? _____

How do your eyes feel after working on computers or using devices? _____

What is the distance from:

Your eyes to the screen? _____

Your eyes to your paper documents? _____

Where is the top of your screen located?

☐ At eye level ☐ Above eye level ☐ Below eye level

Where is the computer screen located?

☐ Directly in front when seated ☐ To your right ☐ To your left

Where are your source documents located?

☐ Directly in front when seated ☐ To your right ☐ To your left

☐ Flat (horizontal) ☐ Vertical

Do you wear glasses, contact lenses, or other optical devices for computer work?

☐ Glasses ☐ Contact lenses ☐ Other: _____

HAVE YOU EVER NOTICED THE FOLLOWING	YES	NO	IF YES, WHEN AND HOW OFTEN
Blurred vision at distance	☐	☐	
Blurred vision at near	☐	☐	
Burning eyes	☐	☐	
Watery eyes	☐	☐	
Eyes hurt / feel tired	☐	☐	
Headaches	☐	☐	
Nausea associated with visual tasks	☐	☐	
Halos around lights	☐	☐	
Doubled vision at distance	☐	☐	
Doubled vision at near	☐	☐	
Tilts head during desk work	☐	☐	
Squint, closing, or covering one eye	☐	☐	
Posture changes when doing desk work	☐	☐	
Need for very bright lights while reading	☐	☐	
Loss of interest, or short attention span, when doing close work	☐	☐	
Difficulty sustaining reading / writing attention	☐	☐	
General / visual fatigue at the end of the day	☐	☐	
Loss of place while reading	☐	☐	
Skipping lines while reading	☐	☐	
Repetition of letters or words when reading	☐	☐	
Omission of words when reading / copying	☐	☐	
Use of finger to keep place	☐	☐	
Head moves when reading	☐	☐	

HAVE YOU EVER NOTICED THE FOLLOWING	YES	NO	IF YES, WHEN AND HOW OFTEN
Confusion of what is being seen or read	☐	☐	
Falling asleep when reading	☐	☐	
Silent vocalization / moving lips when reading	☐	☐	
Motion / car sickness	☐	☐	
Difficulty with reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Letters or words appear to move / float while reading	☐	☐	
Difficulty aligning columns of numbers	☐	☐	
Can respond better orally than via writing	☐	☐	
Writes / prints poorly	☐	☐	
Poor time management	☐	☐	
Inconsistent performance in work / sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulties with short term memory	☐	☐	
Difficulties with long term memory	☐	☐	

PAYMENT POLICY / HIPAA

Examination and procedure fees are due at the time of service and as we are not contracted with any insurance panels, we will not submit this to your medical insurance. We will give you the appropriate coding to seek reimbursement yourself directly, though. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE. THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST. I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Texas Vision Therapy. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "NO-SHOW", "NO-CALL" OR MISSED APPOINTMENT WITHOUT PROPER 24-HOUR NOTIFICATION, WILL BE CHARGED A $200 FEE. We do not schedule the types of exams that you find in routine eyecare offices; as such, we cannot easily fill that missed appointments with a walk-in. Please respect our scheduling. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms. Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your specific visual needs.

If you have any questions, please contact our office at (832)-684-9833 prior to your appointment.

Signature of Responsible Party _____ Date _____