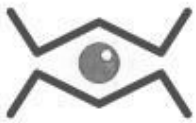

West Michigan Vision Specialists

BRAIN INJURY HISTORY

Name: _____ Date: _____

Who Referred you to **West Michigan Vision Specialists?** _____

MEDICAL HISTORY

Date of Trauma/Injury/Accident: _____

Type of Trauma:

___ Motor Vehicle
___ Blow to Head
___ Drug Abuse
___ Aneurysm
___ Drowning
___ Tumor
___ Industrial accident
___ Poison/Toxic Substance
___ Cord around Neck
___ Medication Related
___ Fall
___ Hemorrhage
___ Stroke
___ Carbon Dioxide

Other: _____

What part of your head was affected? (check all that apply)

___ Forehead
___ Back of Head
___ Right Side
___ Top of Head
___ Left Side
___ Face

Was the trauma open head (bleeding) or closed head (non-bleeding)?_____

Did you lose consciousness? ___ Yes ___ No If yes, how long? _____

Were you in a Coma?___ Yes ___ No If yes, how long? _____

Symptoms immediately following trauma: (check all that apply)

___ Double Vision
___ Loss of Memory
___ Loss of Balance
___ Restricted Field of View
___ Headache
___ Vomiting
___ Dizziness
___ Other _____
___ Blurred Vision
___ Disorientation
___ Restricted Motion
___ Pain in or around eyes
___ Flashes of Light
___ Neck Pain/Whiplash

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____

Name of Doctor: _____Specialty: _____

Where were you seen? _____

Were you hospitalized? ___ Yes ___ No How long? _____

What were you and your family told? _____

_____

What did the initial treatment consist of?_____

What prognosis/recommendations were you given? _____

Were you given medication? ___ Yes ___ No Medication: _____

_____

For what conditions? _____

List any medications, including vitamins and supplements used at the current time:

_____

_____

Do you have a history of allergies? ___ Yes ___ No If yes, please explain _____

_____

Has a Neurological evaluation been performed: ___ Yes ___ No

If yes, by whom? _____ Date: _____

Results: _____

Has a Psychological Evaluation been performed? ___ Yes ___ No

If yes, by whom? _____ Date: _____

Results: _____

Has a Speech and Language evaluation been performed? ___ Yes ___ No

If yes, by whom? _____ Date: _____

Results: _____

SUBSEQUENT SYMPTOMS/ EXPERIENCES:

___Blurred Vision, Distance Viewing
___Blurred Vision, Near Viewing
___Slow to shift focus, near to far to near
___Difficulty taking notes
___Pulling or Tugging sensation around eyes

___Difficulty moving or turning eyes
___Pain with movement of eyes
___Wandering eye
___Double vision
___Loss of Place while reading

___Discomfort while reading
___Unable to sustain near work/reading for adequate periods
___General fatigue while reading
___Eyes get tired while reading
___Headaches

___Pain in and around eyes
___Easily Distracted
___Decreased attention span
___Reduced concentration ability
___Difficulty remembering what has been read

___Difficulty remembering names of objects
___Difficulty remembering peoples Names
___Difficulty recalling information known in past
___Difficulty recognizing formerly familiar objects
___Difficulty recognizing formerly familiar people

___ Difficulty remembering things heard
___ Difficulty remembering things seen
___ Dizziness
___ Poor coordination
___ Clumsiness

___ Loss of balance
___ Poor eye hand coordination
___ Poor handwriting
___ Poor Posture
___ Head tilt

___ Face turn
___ Covering, closing one eye
___ Disorientation
___ Get lost often
___ Bothered by movement around you

___ Bothered by noises around you
___ Bothered by being touched
___ Abnormal general fatigue
___ Reduced depth perception
___ Light sensitivity

___ Flashes of light
___ Floaters in field of view
___ Restricted field of vision
___ Tunnel vision
___ "Curtain" billowing into field of view

SUBSEQUENT PROFESSIONAL CARE

PLEASE BE AS COMPLETE AS POSSIBLE

Physician's Name: _____ Phone:_____

Address: _____

Physiatrist's Name: _____ Phone:_____

Address: _____

Neurologist's Name: _____ Phone:_____

Address: _____

Neuropsychologist's Name: _____ Phone:_____

Address: _____

Physical Therapist's Name: _____ Phone:_____

Address: _____

Speech/Language Therapist's Name: _____ Phone:_____

Address: _____

Occupational Therapist's Name: _____ Phone:_____

Address: _____

Psychologist/Psychiatrist's Name: _____ Phone: _____

Address: _____

Chiropractor's Name: _____ Phone: _____

Address: _____

Residential House Manager:_____ Phone: _____

Address: _____

Case Manager: _____ Phone: _____

Address: _____

Attorney: _____ Phone: _____

Address: _____

Parent/ Guardian: _____ Phone: _____

Address: _____