

Vision Learning Center™ - ACQUIRED BRAIN INJURY SUPPLEMENTAL QUESTIONNAIRE

Full Name _____ Birth Date ____ / ____ / ____ Age: _____
 Nickname _____ Date of Accident _____

WHAT PART OF THE HEAD WAS AFFECTED? (check all that apply):

Forehead Right side Left side Back of head Top of head Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Was there lose consciousness? Yes No If yes, for how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

Double vision Headache Blurred vision Pain in or around eyes Dizziness

Vomiting Flashes of light Disorientation Loss of balance Neck pain/whiplash

Loss of memory Restricted field of view Restricted motion

Other: _____

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 prognosis/recommendations were you given? _____

List any medications, including vitamins and supplements still being used: _____

SUBSEQUENT/OTHER PROFESSIONALCARE

Has any imaging been performed (i.e. MRI, CAT, X-RAY)? Yes No If yes, what kind?

Type _____ Date: _____ Results: _____

Type _____ Date: _____ Results: _____

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING DUE TO THE INJURY
 (List care such as neurological, psychological, occupational therapy, physical therapy, speech, auditory, chiropractic,
 osteopathic, acupuncture, neurofeedback)

DATE	TYPE OF EVALUATION	BY WHOM	DIAGNOSIS / RESULTS	STILL IN TREATMENT?
_____	_____	_____	_____	Y / N
_____	_____	_____	_____	Y / N
_____	_____	_____	_____	Y / N
_____	_____	_____	_____	Y / N

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Difficulty, tugging or pain when moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision comes and goes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty changing focus far to near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement of objects is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bright light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flourescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilts during desk work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold books too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words jump or move around when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span for reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip words frequently when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distracted by things in peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objects jump in and out of field of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced depth perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tunnel vision / Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with bathing / personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty following a series of directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty using both sides of the body together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears Ringing / Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion / Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get lost often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering name of objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty recalling information known in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering formerly familiar people/objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty performing tasks formerly easy/routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty counting money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes No If yes, please explain (please include effects involving home, work, hobbies social and personal relationships):

What activities comprise the majority of your daily life since your accident/injury? _____

What activities can you no longer engage in due to your visual or other difficulties? _____

What other changes/limitations in your daily life do you attribute to your accident/injury? _____
