ANN ARBOR
optometry

VISION REHABILITATION QUESTIONNAIRE

Date: _____

Patient's Name: _____ Male □ Female □

Referred by: _____

GENERAL INFORMATION

Date of Injury: _____ Type of Injury:_____

_____

_____

Please explain how the injury occurred:

_____

_____

_____

_____

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

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

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

Were you in a coma? □ Yes □ No If yes, for how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING INJURY (check all that apply):

□ Double Vision □ Headache □ Blurred vision □ Pain in or around eyes
□ Loss of Balance □ Dizziness □ Vomiting □ Flashes of light

☐Disorientation ☐Neck pain ☐Loss of memory ☐Restricted field of view
☐Other: _____

INITIAL TREATMENT

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

Name of Doctor: _____ Specialty: _____

Additional Doctors/Therapists:

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Were you hospitalized? □ Yes □ No

Where? _____ For how long? _____

Other types of treatments: _____

_____

_____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? □ Yes □ No

If yes, please explain (include home, work, hobbies, social and personal relationships):

_____

_____

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

_____

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

_____

What do you hope a Visual Rehabilitation Program can do for you? _____

_____

_____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE):

What is your current employment position? _____

How many hours daily are spent at a desk? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent on a computer? _____