ABI Questionnaire

This questionnaire needs to be filled out completely and returned to the office to be added to your patient file. PLEASE PRINT

Patient's Name: ____
Patient's Address: ____
____
Patient's Phone Number: (______) _________-_____________
Date of Birth: ______/_______/___________
Date of Brain Injury/Accident/Incident: ______/_______/___________
State where accident/incident occurred: __________________________
Caregiver's Name (if applicable): ____

1. Type of Brain Injury (stroke, motor vehicle accident, hemorrhage, tumor, etc……..) Or any Neurological Situations: ____
   ____
   ____
   ____

   Please list any specifics of the accident/incident:

   ____
   ____
   ____

2. Were you in a coma? Y __ N__ If so, how long? __________________________

3. What loss of function did injury cause (loss of speech, mobility, memory, etc……)?
   ____

4. How long did it take you to recover from any losses sustained? ___________________________

5. What medications are you currently taking? For what? __________________________________
   ____
   ____
   ____

6. Please check any of the following complaints that apply to you:

___ Dizziness Currently Improving Worsening Resolved

___ Headaches Currently Improving Worsening Resolved

___ Double Vision Currently Improving Worsening Resolved

___ Squinting Currently Improving Worsening Resolved

___ Blur up close Currently Improving Worsening Resolved

___ Blur far away Currently Improving Worsening Resolved

___ Night vision problems Currently Improving Worsening Resolved

___ Sleepy when reading Currently Improving Worsening Resolved

___ Eyes water easily Currently Improving Worsening Resolved

___ Light Sensitivity Currently Improving Worsening Resolved

___ Redness of eyes Currently Improving Worsening Resolved

___ Discharge from eyes Currently Improving Worsening Resolved

___ Allergies or hay fever Currently Improving Worsening Resolved

___Reading held 10" or less Currently Improving Worsening Resolved

___ Frequent loss of place when reading Currently Improving Worsening Resolved

___ Nausea or stomach problems Currently Improving Worsening Resolved

___ Pain in or around eyes Currently Improving Worsening Resolved

___ Recurrent neck or back problems Currently Improving Worsening Resolved

___ Motion sickness when reading in a car Currently Improving Worsening Resolved

___ Words appear to run off page when reading Currently Improving Worsening Resolved

7. Did you experience any of the above visual symptoms prior to your injury? If so, please list.

____

____

____

8. Were you an avid reader before the injury? How long and how much did you read?

____

9. Have you had any eye surgeries (cataracts removed, strabismus surgery, RK)? _______________

10. What is your current occupation? ____

11. What was your pre-injury occupation? ____

12. If you are in a job rehabilitation training program, for what job are you being trained?
____

13. Did you have any health problems prior to your injury? If yes, please explain.
____
____
____

14. What was your pre-injury eye health (nearsighted, farsighted, etc..)? Did you wear glasses or contact lenses prior to your injury? ____
____

15. What is your current living situation (assisted living, group home, live-in help or non-assisted living)? ____

16. Will your living situation be changing in the next 3 months? 6 months? 9months? 1 year?
____

17. In what rehabilitation programs are you currently enrolled? _______________________________

18. Are you on a waiting list for any rehabilitation programs? Y ___ N ___

19. What demands are placed on you outside of rehabilitation (homework, job, etc….)?
____
____

20. Will we be working in conjunction with another rehabilitative professional? Y ___ N ___

21. What are your specific goals? If vision therapy is an option, are you willing to pursue it? What do you hope we can do for you in vision training? Be as specific as possible (no more double vision, no more headaches, etc.) ____
____
____

22. Is there pending litigation due to the injury? If so, please list the name of the attorney with address and phone number. Y ___ N ___

Attorney Name: _______________________________ Phone: **(______) ________-_________**
Address: _____________________________________ Fax #: **(______) ________-_________**

23. What doctors have you seen for evaluation and treatment of your injury? Please list below with complete information?

Doctor's Name: ______________________________________ Phone: **(______) ________-_________**

Specialty: ____

Address: ____

Doctor's Name: ______________________________________ Phone: **(______) ________-_________**

Specialty: ____

Address: ____

Doctor's Name: ______________________________________ Phone: **(______) ________-_________**

Specialty: ____

Address: ____

Doctor's Name: ______________________________________ Phone: **(______) ________-_________**

Specialty: ____

Address: ____

Previous Eye Doctor's Name: ____________________________ Phone: **(______) ________-_________**

24. Has the form been completed by the injured person? If no, please list the name of the person providing the information and the relationship to the injured person (spouse, parent, caregiver.)

____

Name Relationship

RELEASE OF REPORT:

By signing this release, you are granting Northwest Eyecare Professionals permission to provide the following clinical providers a copy of your narrative or referral letter, if completed after the examination.

- ☐ I authorize the release of my initial consultation letter to:

  ____
  ____
  ____
  ____

Northwest Eyecare Professionals:

Bruce Wojciechowski O.D., F.C.O.V.D.
John Reski O.D., F.C.O.V.D.
Rachel Jorgensen O.D., F.C.O.V.D.
Julia Sirianni O.D., F.C.O.V.D.
Macson Lee O.D., F.C.O.V.D.
Elizabeth Powers O.D.
Kevin Dittlinger O.D.
Christy Alfano O.D.

15259 SE 82nd DR #101
Portland, OR 97015
(503) 657-0321
Fax# (503) 657-7066

1401 SE 164th Ave #100
Vancouver, WA 98683
(360) 546-2046
(360) 574-5576

10970 SW Barnes Rd
Beaverton, OR 97225
(503) 214-1396
(503) 469-0766

5880 NE Cornell Rd #B
Hillsboro, OR 97124
(503) 905-2828
(503) 905-2829

Patient's Name: ____
Patient's Address: ____
____
Patient's Phone Number: (______) _________-_____________
Date of Birth: ______/_______/___________

____________________________________ ________________________

Patient Name Date

****If you want to request incoming or outgoing records, a medical release of information will need to be filled out and submitted to our medical records coordinator****