Lynn H. Trieu, OD, MS
Fellow, American Academy of Optometry
Fellow, College of Optometrists in Vision Development

True Vision Therapy, LLC
Pediatric Eye Care and Vision Therapy
Neuro-Optometry and Rehabilitation

Questionnaire for Adult and Brain Injury Patients

Name _____F ☐ M ☐ _____ ☐ DOB _____ Age _____ Today's Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Email _____ Occupation_____Referred by_____

Fill Out If Patient is a Minor

Parents' Names: Parent 1: _____Parent 2:_____

Occupations: Parent 1: _____Parent 2: _____Marital Status: Married ☐ Single ☐ Divorced ☐

Patient's Previous Diagnosis:_____Adopted: Yes ☐ No ☐

Reason for today's visit (include any visual symptoms you are experiencing):

When did the problem(s) start?

Did you suffer from an accident, brain injury, or stroke? Yes ☐ No ☐ If yes, please describe how it occurred.

Have you seen any other professionals regarding this problem? Yes ☐ No ☐ If yes, please list the names of the professionals and describe findings.

Visual History

When was your last eye examination?

Who is your primary eye doctor? Name:

Address:

Phone:

Are you being followed by any other eye doctors regarding your eyes or vision?

Please describe any previous eye or vision problems and visual treatment you have received (including glasses, vision therapy, patching, surgery, or medications).

Please check any of the following symptoms that apply to you:

- ☐ blurred distance vision
- ☐ blurred vision during reading
- ☐ double vision
- ☐ fatigue during near visual tasks
- ☐ words moving or running together
- ☐ eye strain or pain
- ☐ frequent headaches
- ☐ eyes cross or drift in/out or up/down
- ☐ close one eye when reading
- ☐ hold reading material too close
- ☐ turn or tilt head
- ☐ squint or blink excessively
- ☐ rub eyes during reading
- ☐ skip or reread words and lines
- ☐ loss of place when reading
- ☐ head movement when reading
- ☐ use finger or underliner to read
- ☐ red or teary eyes
- ☐ avoid near work
- ☐ poor depth perception
- ☐ poor eye-hand coordination
- ☐ do not enjoy sports
- ☐ dizziness
- ☐ motion sickness
- ☐ loss of balance
- ☐ loss of memory
- ☐ restricted eye motion
- ☐ restricted field of view
- ☐ disorientation
- ☐ poor night vision
- ☐ light sensitivity
- ☐ other (please describe)

Medical History

When was your last physical examination or doctor's visit?

Who is your primary care provider? Name:

Address:

Phone:

Do you suffer from any health problems, including any allergies or asthma? Yes ☐ No ☐ If yes, please describe.

Have you had any severe illnesses, injuries, or hospitalization? Yes ☐ No ☐ If yes, please describe.

Are you taking any medications? Yes ☐ No ☐ If yes, please list:

Are you being followed by any other health care professionals? If yes, please list their names and reason for care.

Family History

Does anyone in the family have any of the following? Relationship to You

- ☐ strabismus (crossed eyes or drifting eyes) _____
- ☐ amblyopia (lazy eye) _____
- ☐ high nearsightedness, farsightedness, or astigmatism _____
- ☐ learning or reading problems _____
- ☐ blindness _____
- ☐ eye disease (please describe) _____

Thank you for carefully completing this questionnaire.

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Notice of Privacy Practices Acknowledgement

Consent to use or disclose health information for the treatment, payment, and health care operations

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers

True Vision Therapy has a comprehensive *Notice of Privacy Practices* that describes how the practice may use and disclose my health information. I may request a personal copy of the *Notice of Privacy Practices* at any time. By signing this document, I acknowledge that I have been offered a copy of the *Notice of Privacy Practices*. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please note that the *Notice of Privacy Practices* explains how True Vision Therapy contacts patients by phone, email, and text message about appointment times, recommended treatments, and in response to questions. I can consult the *Notice* for a full explanation of these practices. While True Vision Therapy's email and records are protected by HIPAA-compliant agreements, I acknowledge that my personal email, phone, and computer may not be. I also understand that if I prefer not to be contacted by any of the means outlined above, I may provide written notice to True Vision Therapy at any time.

I understand that I may request in writing that True Vision Therapy restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand True Vision Therapy is not required to agree to my requested restrictions, but if this practice does agree then it is bound to abide by such restrictions.

I have reviewed, understand, and agree to the content of the notice of privacy practices and this consent. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.

Patient name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please note your relationship as the source of authority to sign this form.

Signature: _____ Relationship: _____

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Ocular Health Statement

Reminder that our office does not perform ocular health examinations

I understand that **Dr. Lynn Trieu's evaluation is a functional eye examination**, meaning that it looks at how comfortably and easily the eyes work together in my everyday life. It is intended to examine eye alignment, the coordination of muscles around the eyes (extraocular muscles), and focusing (ciliary) muscles. Her examination neither confirms nor denies any ocular health condition outside of the functional vision examination.

Dr. Trieu will not perform a routine ocular health check. This means that she will not perform an examination of the external parts of my eye, including the eyelids, sclerae, cornea, and lens; she will not perform a dilated fundus exam to check the health of the retina and optic nerve; and she will not perform an intraocular pressure check. All of these procedures should be performed at a separate examination as part of my routine ocular health management.

If I do not have a primary eye care provider or know of one, this office is happy to recommend someone in my area. Dr. Trieu recommends regularly scheduled ocular health checks, especially for patients who are diabetic, hypertensive, have systemic diseases that may affect vision, have cataracts, have a strong glasses prescription, have had an eye injury, have a family history of eye disease, or are 45 years of age or older. An immediate ocular health check is recommended if I have any of the following symptoms:

1. Sudden appearance of a curtain or shadow coming over my field of vision.
2. Onset or marked increase of flashes of light, often similar to lightening streaks, which may be more noticeable in the dark.
3. Sudden change or decrease in vision in one eye or both eyes.
4. Sudden appearance of new cobwebs or spider-like figures in my vision.
5. Sudden appearance of many new black dots, commonly known as floaters.

I have reviewed, understand, and agree to the above statement.

Patient name: _____ Date: _____

Patient Signature: _____

If you are signing as a personal representative of the patient, please note your relationship as the source of authority to sign this form.

Signature: _____ Relationship: _____