The Center for Vision Development & Performance Vision Therapy

The following information will help prepare you for the upcoming appointment at our office. Your timely completion of the attached documents will allow us the needed time to process and review your case in advance. We ask that every page be filled out in its entirety and all pertinent medical records including your last eye exam are returned to our office **at least two business days prior to your scheduled evaluation**.

What is a Developmental Vision Evaluation?

A Developmental Vision Evaluation includes checking the general health of the eye, visual acuity (20/20), refractive condition for appropriate corrective lenses when needed and all of the visual functions required for reading, writing, learning, sports performance and functioning in life. A developmental vision evaluation helps to pinpoint the precise area(s) of concern as well as the depth of the problem and to determine the best treatment options.

What tests are performed?

Sensorimotor Testing- measures ocular motility, ocular alignment, and ocular deviation in more than one area of gaze and binocular fusion. It is necessary for detection, assessment, monitoring and guidance for the medical, surgical and optical management of binocular function and motor eye misalignment.

Visual Perceptual Testing- tests the brain's ability to make sense of what the eyes see. It is important for everyday activities such as dressing, eating, writing, and working. When you have a visual processing dysfunction, more cognitive effort is needed for every day activities.

How long does testing take?

Testing takes approximately 2 hours and is scheduled in the morning before the eyes and brain are tired from a full day of school or work. We like to do testing at this time so you have eaten a good, high protein meal and are most attentive.

Who can come to the appointment?

Because full attention is needed, it is very important that you **do not bring any additional family members other than your spouse to the evaluation**. We ask that only the patient or patient and spouse attend. This minimizes distraction and enhances the productivity of the time spent in our office.

What is my financial policy?

Third-parties, such as medical insurance, Medicare and TennCare, severely limit treatment, care options, and the time the Doctor and team can spend with you. Therefore, The Center for Vision Development and Performance Vision Therapy is a fee-for-service facility and payment is due in full at the time of service. The total cost of the Initial Visit is $275, which includes the evaluation, testing, consultation, and a follow-up summary of the Doctor's findings.

Will I get the results the same day?

Yes! During your consultation all of the findings will be explained to you and literature will be provided. The recommendations from the Doctor, how to proceed and expectations will also be explained.

We look forward to meeting you and if you have any additional questions, please feel free to contact us at:

The Center for Vision Development
400 Sugartree Lane, Suite 310
615-791-5766
info@thecenterforvision.com

Performance Vision Therapy
3252 Aspen Grove Drive, Suite 12
615-905-4668
info@tnperformancevision.com

Over 18 Adult History Form

Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.

Full Name:_____ Nickname:_____

DOB:_____ Age: _____ Gender: Male or Female

Address:_____ City:_____ Zip:_____

Cell Phone:_____ Email:_____

Place of Employment: _____ Occupation: _____

Are you currently enrolled in School? Yes ☐ No ☐

Name of School:_____ Area of Study: _____

Spouses Name: _____ Phone Number: _____

Place of Employment: _____ Occupation: _____

HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business _____

Internet: Which terms did you search? _____

Current/Previous Patient: _____

Facebook Instagram LinkedIn Driving By

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Cell Phone: _____

Relationship: _____ Email: _____

Place of Employment: _____ Work Phone: _____

MEDICAL HISTORY: *Please fully complete*

Medical Doctor's Name:_____ Date of Last Visit: _____

Practice Name: _____

Current Medications (include vitamins/supplements):_____

_____

_____

Are you allergic to any medications? If yes, please list or circle **No Know Drug Allergies**

Tobacco use? Yes No Packs/day:_____ Narcotic use? Yes No

Alcohol use? Yes No Drinks/day:_____

Over 18 Adult History Form

Please indicate if you have or had any problems with any of the following.

Event/Condition	Yes/No	Please describe, including time of onset.
Constitutional Symptoms (e.g. fever, weight loss)		
Hematologic/Bleeding Disorder		
Allergies/Immunologic Disorder		
Endocrine		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
ENT or Vestibular		
Gastrointestinal		
Skin Disorders		
Musculoskeletal		
Genitourinary		

HAVE YOU EVER EXPERIENCED- check all that apply

Motor Vehicle Accident		Been Physically Assaulted		Oxygen Deprived at Birth or anytime		Abnormal MRI or CT Scan	
Whiplash		Blunt Force Trauma		Any Injury at Birth		Lyme, Measles, Shingles	
Motorsports Accident		Victim of Domestic Violence		Brain Tumor, Aneurysm, hemorrhage		Vestibular (dizziness, balance, tinnitus)	
Skull Fracture		Slip & Fall Head Injury		Stroke or TIA		Bicycle Accident	
Played contact sports in school		Work Related Injury		Epilepsy or Seizures		Drug or Alcohol Overdose	

Explain: _____

_____

List any major illnesses, injuries, surgeries, or hospitalizations: _____

Over 18 Adult History Form

VISUAL HISTORY

Has there been previous vision care? Yes No Date of Last Visit: _____

Eye Doctor's Name:_____ (Please have these records faxed to our office)

Practice Name: _____

Do you have glasses now? Yes No Do you wear them? Yes No
If yes, when should you wear them?_____

Do you wear contact lenses? Yes No If yes, brand and powers: _____

Do you have any of the following eye conditions? (Please circle all that apply) Glaucoma Blindness Amblyopia/Lazy eye Strabismus/Crossed Eye Cataracts Macular Degeneration

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Do you notice any of the following?

Please check all that apply

- ☐ Blurred vision in the distance or near
- ☐ Difficulty focusing near/far
- ☐ Eyestrain, fatigue, headaches
- ☐ Frowns/squints or has facial tension
- ☐ Reduced reading comprehension/retention
- ☐ Skip words or loses place when reading
- ☐ Slow reader
- ☐ Confuses letters or words
- ☐ Eye turn, lazy eye, wandering eye
- ☐ Double vision
- ☐ Cover/close one eye when reading/writing
- ☐ Tilt or turns head to see
- ☐ Letters or lines float, run together or jump
- ☐ Difficulty or pain with eye movements
- ☐ Restricted field of vision (peripheral)
- ☐ Tunnel Vision
- ☐ Difficulty recalling information
- ☐ Loss of long or short term memory
- ☐ Poor eye-hand coordination
- ☐ Clumsy, accident-prone
- ☐ Difficulty judging distances or objects
- ☐ Poor Depth Perception (3D movie, parking)
- ☐ Difficulty with navigation or direction
- ☐ Hearing loss and/or ringing in the ears
- ☐ Dizziness or loss of balance
- ☐ Disorientation
- ☐ Motion sickness
- ☐ Light or noise sensitivity
- ☐ Flashes of Light
- ☐ Sensory issues
- ☐ Difficulty driving (morning or night)
- ☐ Can't tolerate visually busy places
- ☐ Auditory Learner
- ☐ Moves lips when reading silently
- ☐ Vocalizes or moves lips when others talk
- ☐ Difficulty following verbal instructions
- ☐ Poor time management, always late
- ☐ Short attention span or distractible
- ☐ Difficulty attending to detail
- ☐ Anxiety
- ☐ Extreme stress
- ☐ Visual changes due to weather changes
- ☐ Visual changes after eating
- ☐ Visual changes **only** after prolonged computer or cell phone use
- ☐ Visual changes when getting up too quickly from laying/sitting to standing
- ☐ Visual changes after rosacea flare up
- ☐ Visual changes started after new medication

Other: _____

Over 18 Adult History Form

SPECIALISTS (must be completed)

Neurologist: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Psychologist/Psychiatrist: □ Yes □ No Currently in treatment? □ Yes □ No
Tester Name & Title: _____ Phone: _____
Facility Name & Address: _____

Occupational Therapist: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Speech Therapist: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Physical Therapist: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Audiologist/Vestibular Rehab: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Physiatrist: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Chiropractor: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Naturopathic Doctor: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Infectious Disease/Internal Medicine: □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____

Over 18 Adult History Form

SCREEN TIME

Average screen time per day (TV, tablets, computers, phones, etc.):_____

How do your eyes feel after working on the computer? _____

Where is the top of the screen located (circle): above eye level at eye level below eye level

What is the distance from your eyes to the screen? ____ To your source document? _____

Where is the computer screen located (circle): directly in front to your right to your left flat (horizontal) vertical multiple screens

Do you experience any of the following in your work area (circle)? Glare Reflections Difficulty Reading Difficulty changing focus after computer use

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GENERAL BEHAVIOR

Any challenges at work/school/home? If so, what are they and are there specific triggers?

_____

Any traumatic life events? (separation/divorce, loss of family member, military, major illness)

_____

What best describes your activity level? □ Inactive □ Moderate □ Extreme

Do you use a wheelchair? Yes No Can you sit in an examination chair? Yes No

Any pending lawsuits due to injury? Yes No Firm representing you:_____

SLEEP HABITS

How many hours of sleep do you get each night? _____ What time do you go to bed? _____

Do you sleep through the night? □ Yes □ No Do you use any sleep aids? □ Yes □ No

Have you been diagnosed with sleep apnea? □ Yes □ No Age at diagnosis? _____

Do you/you child use CPAP/BiPAP? □ Yes □ No

I hereby give my permission to The Center for Vision Development and/or Performance Vision Therapy to treat:

_____
Patient's Name

_____ _____
Patient, Parent, or Guardian's Signature Date

Over 18 Adult History Form

Release of information:
It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care, with your permission. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my examination records to be forwarded to myself or other health care providers upon their written request or upon recommendation of The Center for Vision Development and/or Performance Vision Therapy when it is necessary for the treatment of my visual condition. I authorize The Center for Vision Development, Performance Vision Therapy, and/or their staff to exchange information with other professionals involved in my care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
Signature Date

_____
Relationship to patient

Release of Information to Non-Medical Staff/Family Members

I, _____, give permission for The Center for Vision Development and Performance Vision Therapy to release medical information to the following non-medical individual(s). (Family members (do not include parents/legal guardians), teachers, tutors, coaches)

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

_____ _____
Signature Date

_____
Relationship to patient