True Vision Therapy
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Dr. Lynn Trieu and Associates
Pediatric Eye Care and Vision Therapy
Neuro-Optometry and Concussion Rehab

Questionnaire for Adult and Brain Injury Patients

Today's Date _____ Name _____ DOB _____

Age _____ M ☐ F ☐ Non-Binary ☐ Occupation _____ Employer _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ If Student: Grade _____ School _____

Referred by _____ Previous Diagnosis _____

How would you like to receive your vision report? Email (unencrypted attachment) ☐ Standard mail ☐

Fill Out If Patient is a Minor

Parents' Names – Parent 1: _____ Parent 2: _____

Parents' Occupations – Parent 1: _____ Parent 2: _____

Marital Status: Married ☐ Single ☐ Divorced ☐

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

Were you adopted? Yes ☐ No ☐

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.