☐ I have had a medical diagnosis of brain injury (check box if true). My brain injury was: ____ years ago
☐ I suffered a brain injury without medical diagnosis (check box if true)
☐ I have NOT had a previous brain injury (check box if true)
your age _____ today's date: ____________ your zip code: __________

Please check the most appropriate box, or circle the item number that best matches your observations. All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behavior occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Outdoor light too bright – have to use sunglasses	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4

Fax to Laukkanen: **503-352-3033 -** or mail to: Bighill c/o PUCO, 2043 College Way, Forest Grove, OR 97116

Vision Sense
Optometry

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Halifax, N.S B3S 1B8
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902.454.1520

Neuro-Optometric Traumatic Brain Injury Assessment

Personal Information

Name: ____ **Date:** ____________________________

Address: ____

Home Phone: ________________ **Cell Phone:** __________________ **Work Phone:** ____________________

Date of Birth *(mm/dd/yyyy)*: __________________ **Email Address:** _________________________________

Allergies (to Medications, Environment): ____

Allergies/Sensitivity (to food): ____

Occupation: _________________________ **Employer:** ____

Referred by: _____________ **Optometrist:** ______________________ **Last Eye Exam:** __________________

Family Doctor: ___________________ **Medications:** ____

____

Preferred hand: ___ left ___ right **Do you wear:** ___ eyeglasses ___ contact lenses ___ reading/computer glasses

Have you ever had eye surgery? ___ yes ___ no **Date:** _________________ **Type:** _______________________

Trauma Information

Date of accident/trauma: _____________________ **Referred by:** _________________________________

Describe the accident/trauma: ____

____

____

Insurance Information

Insurance Company: ______________________________ **Claim #:** _________________________________

Adjuster Name: __________________________________ **Email Address:** ____________________________

Phone Number: __________________________________ **Fax Number:** ______________________________

Lawyer Information

Company Name: ____________________________ **Lawyer Name:** ___________________

Email Address: ____________________________ **Phone Number:** ___________________

Fax Number: ______________________________

Type of Accident

Motor Vehicle

What type of vehicle were you in? ____

If other vehicle(s) were involved, please list the type(s): ____

Where were you sitting in the vehicle?

___ Front Seat ___ Left Side ___ Middle ___ Back Seat ___ Right Side ___ Unusual Position

What was the speed of vehicle you were in? ________ **What was the speed of the other object or vehicle?** _________

Did your vehicle hit another object? ___ Yes ___ No **or** **Did another vehicle hit your vehicle?** ___ Yes ___ No

If yes, where was your vehicle hit? (please check all that apply)

____ Head On ____ Toward Front _____ Driver Side ____ Rear Ended ____ Toward Rear ___ Passenger Side

Did you experience whiplash? ___ Yes ___ No **Did you experience loss of consciousness?** ___ Yes ___ No

Did you hit your head? ___ Yes ___ No **If yes, on what?** ____

Other Accidents

Type (ex: previous home, industrial, fall, hit by object, etc.): ____

Please describe: ____

____

Toxic (ex: medication related, drug abuse, poison, etc.): **Please describe**: ____

____

Anoxic (ex: drowning, C02, anesthesia, cord around neck, etc.). **Please describe:** ___________________________________

____

Vascular (ex: stroke, aneurysm, hemorrhage, etc.): **Please describe:** ____

____

Head Injury Description

What part of your head was affected? __ Forehead __ Right Side __ Top __ Back of Head __Left Side __ Face

Were you unconscious? ___ Yes ___ No **If so, for how long?** ____

Comments ____

____

Present symptoms (Check all that apply)

Present Symptoms	✓	Intensity on a scale of 1-10	Was it present before the accident?	Has it worsened since the accident?
Blurred vision at a distance				
Blurred vision at near				
Double vision				
Light sensitivity				
Tunnel vision				
Dizziness				
Disorientation				
Nausea				
Headache				
Pain in or around eyes				
Discomfort when reading				
General fatigue when reading				
Restrictive field of view				
Difficulty perceiving where things are				
Closing or covering one eye				
Flashes of light				
Sensitivity to noises				
Easily distracted				
Difficulty with short term memory				
Loss of balance				
Poor coordination				
Head tilt or turn				
Restricted motion				
Sensitivity to motion				
Bothered by movement around you				

Other Difficulties Following Accident

Work - Please describe: ____

Hobbies/Social - Please describe: ____

Other - Please describe: ____

Headache Characteristics

On average how often do you have headaches? _____times each __Day __Week __Month __Have them all the time

Intensity of the headaches: How bad are your headaches? On a scale of 0 to 10 (with 0=no pain and 10=bad pain)

With medication: _____ Without medication: ____

Headaches prevent activities: _____________________________________ School Work Household Chores

Location of Headaches: Where do you feel the pain during your headaches?

__Left side __Right side __Forehead __Temple __Behind eye(s) __Back of head __Neck __Other__________

Effect of headaches on ability to function:

___ Normal function ___ Slightly decreased ___ Severely decreased ___ I am totally bedridden

Physical Challenges (Please indicate intensity on scale of 1 to 10)

Lower back pain: ____________

Middle back pain: ___________

Shoulder area pain: __________

Neck pain: _________________

Hip pain: __________________

Knee pain: _______________________

Feet and ankle pain: ______________

Sternum and clavicle area pain: _____

Arm and wrist pain: _______________

TMJ, jaw pain: ___________________

Initial Care

Did you see a doctor concerning the accident? ___ Yes ___ No

Whom did you see? ___________________________________ **When?** ____

Where? ______________________________ **What was the diagnosis?** ____

Comments: ____

____

____

Subsequent/Other Professional Care

What kind of professional care for your injuries/trauma have you received and what care do you continue to receive?

(Please note the most recent visit to each healthcare professional.)

	Name	Date
Family Physician		
Audiologist		
Chiropractor		
Counscellor		
Massage Therapist		
Naturopath		

Neurologist ____

Occupational Therapist ____

Ophthalmologist ____

Optometrist ____

Osteopath ____

Physiotherapist ____

Psychiatrist ____

Psychologist ____

Physiatrist ____

Speech Therapist ____

Other ____

Other Information:

Please take the time to share with us anything else that you feel is relevant:

____

____

____

____

____

____