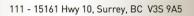


Office | 604.576.6588 Fax | 604.576.7988 Email | info@panoramaoptometry.com www.panoramaoptometry.com

VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office prior to your appointment. Thank you

Appointment: Date: Time:	
GENERAL INFORMATION	
Full Legal Name: Birth Date: Home Address:Mobile Phone: Email address:(What is your occupation? Are you currently working?	Work Phone: Care Card Number:
Were you referred to our office?	□ NoProfession:
Last Medical Checkup: Name of List of Current Medications and Supplements:	
Do you have any allergies? If so, please list:	
Date of injury/accident:	
Did you lose consciousness? If yes, for how long:_	





Office | 604.576.6588 Fax | 604.576.7988 Email | info@panoramaoptometry.com www.panoramaoptometry.com

What types of professional current recommendations		u received or a	are currently receiving? Please list the professionals name and
Physiotherapy			
Neuropsychologist			
Audiologist			
MEDICAL HISTORY Have you or anyone in y High blood pressure Diabetes Heart Condition Stroke Cholesterol Thyroid Condition Cancer Glaucoma Cataracts Macular Degeneration Blindness Strabismus Amblyopia Other personal or family r	Patient	Family	any of the following conditions: Whom
Do you smoke? ☐ Yes Do you drink? ☐ Yes	□ No	If yes, how	





Office | 604.576.6588 Fax | 604.576.7988 Email | info@panoramaoptometry.com www.panoramaoptometry.com

VISUAL HISTORY				
Do you wear glasses	s or contact lenses?	Doctors Nar s, what happened and whe		
Have you ever had a	any eye surgeries? If y	es, what type of surgery a	nd when:	
DO YOU CURRENT	LY EXPERIENCE AN	Y OF THE FOLLOWING (Please circle all that app	oly):
□ Double Vision □ Disorientation □ Loss of balance □ Motion sickness Other:	■ Light Sensitivity		☐ Headache☐ Pain in/around €☐ Restricted field €	5

FINANCIAL POLICY

We require payment at the time of the appointment and we will provide a receipt for reimbursement submission.

BIVSS CHECKLIST (Brain Injury Vision Symptom Survey)

Patient Name:			Today's date:		
My brain injury was:	years ago	My age is:	years	today's date:	
□ I have had <u>a medical d</u>	liagnosis of bra	in injury (check box	if true) Cause	of injury:	
□ I sustained a brain inju	ry without med	ical diagnosis (che	eck box if true)		
□ <u>I have NOT</u> ever susta	ined a brain inj	ury (check box if true)			
Please check the most app		ircle the item numi d in confidence. Ti			s. All information will

MPTOM 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				ı	
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			ı	1	
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			ı	ı	
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 DRY EYES	0	1	2	3	4
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	1	•			
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 aheadisn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING			ı	ı	
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	_	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