HUNTERDON
VISION THERAPY CENTER

Rachel M. Halatin, O.D.
1465 Route 31 South
Annandale, NJ 08801
Tel: (908) 323-2742
Fax: (908) 323-2737

Today's Date

First Name and Last name | Preferred Name | Date of Birth

Address | City | State | Zip

☐ Ok to text?

Home Phone | Cell Phone | Email Address

☐ Ok to e-mail?

Occupation (if student, grade in school) | Employer (if student, name of school)

Name of Insurer for ***MEDICAL*** care

Name of Primary Holder | Primary's Date of Birth | Primary's SSN#

Primary Care Physician | Office Location and Phone | Pharmacy Name | Pharmacy Location

Neurologist | Neurologist Location | Neurologist Phone | Referred by

PAYMENT POLICY & RELEASE OF PATIENT INFORMATION

Payment is expected when services are rendered, unless other arrangements are made in advance. ***It is your responsibility to know your insurance coverage.*** Sensorimotor exams, Visual-Perceptual exams, vision therapy, and neuro-optometric rehabilitation therapy are all **self-pay** services. Pricing is as follows:

- ➔ Sensorimotor exam $350
- ➔ Visual-Perceptual exam $450
- ➔ Vision Therapy $185 per session (discounts will be applied for packages)
- ➔ Vision Therapy Progress Evaluation $175 per visit

I HAVE READ AND UNDERSTAND THE ABOVE

Signature of patient or responsible party | Date

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VISION

REHABILITATION QUESTIONNAIRE

INJURY/ACCIDENT HISTORY

Date of Injury/Accident _____

Type of Injury/Accident *(Circle applicable answer)*

- ☐ Motor Vehicle
- ☐ Fall
- ☐ Blow to head
- ☐ Workplace
- ☐ Industrial
- ☐ Other _____
- ☐ Carbon Dioxide
- ☐ Medication
- ☐ Vaccination
- ☐ Stroke
- ☐ Aneurism

What part of your head was affected? Circle all that apply.

- ☐ Forehead
- ☐ Face
- ☐ Top
- ☐ Back
- ☐ Left
- ☐ Right

Was the injury ☐ Open Head (bleeding) ☐ Closed head (non-bleeding)

Did you lose consciousness? ☐ Yes. If so, how long? _____ ☐ No

Were you in a coma? ☐ Yes. If so, how long? _____ ☐ No

Symptoms immediately following accident/injury. CHECK all that apply.

- ☐ Double vision
- ☐ Blurred vision
- ☐ Disorientation
- ☐ Loss of balance
- ☐ Restricted motion
- ☐ Confusion
- ☐ Headache
- ☐ Dizziness
- ☐ Vomiting
- ☐ Nausea
- ☐ Vertigo
- ☐ Neck pain
- ☐ Flashes
- ☐ Floaters
- ☐ Blind spots
- ☐ Whiplash
- ☐ Pain in or around eyes
- ☐ Restricted field of view
- ☐ Distorted vision
- ☐ Light sensitivity
- ☐ Loss of memory

Has a **neurological** evaluation been performed? If yes, by whom and what were the results? List the date.

_____

Has a **psychological** evaluation been performed? If yes, by whom? List the date.

_____

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Initial Treatment

When did you first see a doctor regarding your accident/injury?

Name of doctor | Specialty

Were you hospitalized? If yes, for how long? | Where?

What were you and your family told?

What did initial treatments consist of?

What prognosis/recommendations were you given and what were the results?

Has a vision/eye evaluation been performed? If yes, whom and when?

Results

Do you <u>currently</u> experience any of the following? (Circle all that apply)

Movement of objects in the environment is bothersome	☐ Yes	☐ No
Patterned wallpaper or carpets is bothersome	☐ Yes	☐ No
Loss of interest/concentration when doing tasks	☐ Yes	☐ No
Objects jump in and out of view	☐ Yes	☐ No
Difficulty coordinating both sides of the body	☐ Yes	☐ No
Confusion or disorientation	☐ Yes	☐ No
Difficulty with remembering things heard	☐ Yes	☐ No
Difficulty with remembering things seen	☐ Yes	☐ No
Difficulty with remembering names of objects	☐ Yes	☐ No
Difficulty with remembering information known in the past	☐ Yes	☐ No
Difficulty with performing routine acts	☐ Yes	☐ No
Difficulty with following a series of directions	☐ Yes	☐ No

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MEDICAL HISTORY

Have there been any severe illnesses, injuries, hospitalizations, or physical impairments. If yes, please describe.

Do you have a history of any of the following? (Circle all that apply.)

- ☐ High Blood pressure
- ☐ Diabetes
- ☐ Thyroid
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ Autoimmune Disease
- ☐ Brain tumor
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Amblyopia
- ☐ Strabismus
- ☐ Asthma
- ☐ COPD
- ☐ Chronic headaches
- ☐ Migraines
- ☐ Seizures

MEDICATIONS/VITAMINS/SUPPLEMENTS

DRUG ALLERGIES AND OTHER SIGNIFICANT ALLERGIES

VISUAL HISTORY

Have you had a previous vision evaluation? If yes, what was the reason? ☐ Yes ☐ No

Were glasses, contact lenses, prisms, or other optical devices recommended? If yes, what? ☐ Yes ☐ No

Were any additional tests, treatments, or therapies recommended concerning your vision? If yes, what? ☐ Yes ☐ No

Did you undergo these treatments? If yes, what were the results? ☐ Yes ☐ No

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LIFESTYLE

Do you feel your vision interferes with activities of daily living? ☐ Yes ☐ No

If yes, please explain including effects involving home, work, hobbies, social, and personal relationships:

What activities comprise the majority of your daily life since your accident/injury?

What activities can you no longer engage in due to your visual or other difficulties?

What other changes/limitations in your daily life do you attribute to your accident/injury?

What do you hope our Neuro-optometric Rehabilitation program can do for you?

Employment/Education Information (if applicable)

What is your current employment position?

If a student, what is the major course of study?

How many hours daily are spent at a desk?

How many hours daily are spent working at nearpoint distance?

How many hours a day are spent reading/working on a computer?

How many hours are you able to sustain concentration at work or at study?

Are you unable to work or attend school due to your accident/injury? ☐ Yes ☐ No

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SUBSEQUENT/OTHER PROFESSIONAL CARE

What types of professional care have you received or are you currently receiving? CURRENT COMPLETED

Psychiatrist Name: ☐ ☐

_____

Results and Recommendations:

Neurologist Name:_____ ☐ ☐

Results and Recommendations:

Neuropsychologist Name:_____ ☐ ☐

Results and Recommendations:

Physical Therapist ☐ ☐

Name:_____

Results and Recommendations:

Vestibular Therapist ☐ ☐

Name:_____

Results and Recommendations:

Cognitive Therapist ☐ ☐

Name:_____

Results and Recommendations:

Speech Language Therapist ☐ ☐

Name:_____

Results and Recommendations:

Osteopathic Physician Name:_____ ☐ ☐

Results and Recommendations:

Chiropractor Name:_____ ☐ ☐

Results and Recommendations:

Nutritionist Name:_____ ☐ ☐

Results and Recommendations:

Other Name:_____ ☐ ☐

Results and Recommendations:

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WHAT IS A BEHAVIORAL/NEURO-OPTOMETRIST – a specialist in the field of optometry who assesses how your vision and visual system work together, allowing you to function comfortably in a school, work, athletic and spatial environment. Dr. Halatin does a 21-point exam designed to determine functional skills. She also checks visual acuity during this exam.

WHAT IS A SENSORIMOTOR EXAM – an assessment that covers all the aspects of a general eye examination, however looks much more closely at a number of different visual skills such as eye teaming, focusing, and visual motor skills. These skills are the building blocks for reaching full potential, particularly in the classroom. This exam is scheduled for 45 minutes. *This visit does not generate a report. Dr. Halatin may recommend a Visual Perceptual Evaluation.* Sensorimotor evaluations are self-pay **$350**.

WHAT IS A VISUAL PERCEPTUAL EVALUATION – this assessment investigates a number of different visual skills which are essential for learning, including visual form perception skills, directionality, visual motor integration, and visual auditory integration.
A nine-page report compiling the findings of both specialized examinations is included with the visual perceptual evaluation. Self-pay **$450**. Testing typically takes **1 ½ hours**. The report takes 3-4 weeks to complete.

WHAT IS VISION/NEURO-OPTOMETRIC THERAPY – an individualized treatment plan consisting of activities designed to remediate the deficits found during testing. The patient attends weekly 45-minute sessions. **Success is dependent upon the patient's motivation and the continuing support of the family, regular attendance at weekly therapy sessions, and the completion of home vision therapy assignments.** Reevaluation will take place every twelve sessions to determine what progress has been made.

There is no way to predict at the onset how long the therapy may last. The therapists need to assess the degree of dynamic (functional) skills and the motivation of the patient and family. Many factors, especially compliance with home support activities can affect the duration. Some patients may be done in 24 weeks, most 36 weeks, and cases like strabismus take at least a year.

Learning is multi-sensorial, and good visual skills are critical for success in the classroom, the playing fields, and workplace. *Vision therapy, however, does not teach reading, writing, or spelling.* It does not replace the support given by the family, speech, and language therapists, PTs or OTs. We cannot reverse certain diagnoses, like autism spectrum or severe nerve damage, but with patient compliance and individual effort, we often see improvements in visual-organization and an increased quality of life.

BRAIN INJURY SYMPTOM CHECKLIST

Date:_____ Patient Name:_____ Age: _____

My brain injury was _____ years ago.

- ☐ I have had a medical diagnosis of brain injury
- ☐ I suffered a brain injury without medical diagnosis
- ☐ I have NOT had a previous brain injury

Please rate the following:

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

SYMPTOMS OF BINOCULAR VISION DYSFUNCTION

Do any of the following apply to you or have been observed by others (family members, peers, etc.) Please hand this checklist to the doctor at the ***beginning*** of your consultation.

	FREQUENT	SOMETIMES
Skips lines while reading or copying	☐	☐
Loses place while reading or copying	☐	☐
Skips words while reading or copying	☐	☐
Substitutes words while reading or copying	☐	☐
Rereads words or lines	☐	☐
Reverses letters, numbers, or words	☐	☐
Uses a finger or marker to keep place while reading/writing	☐	☐
Reads very slowly		
Poor reading comprehension	☐	☐
Difficulty remembering what has been read	☐	☐
Holds head too close when reading/writing (within 7-8 inches)	☐	☐
Squints, closes, or covers one eye while reading	☐	☐
Unusual posture/head tilt when reading/writing	☐	☐
Headaches following intense reading/computer work	☐	☐
Eyes hurt or feel tired after completing a visual task	☐	☐
Feels unusually tired after completing a visual task	☐	☐
Double vision	☐	☐
Vision blurs at distance when looks up from near work	☐	☐
Letters or lines “run together” or words “jump” when reading	☐	☐
Print seems to move or go in and out of focus when reading	☐	☐
Poor spelling skills	☐	☐
Writing is crooked or poorly spaced	☐	☐
Misaligned letter or numbers	☐	☐
Makes errors copying	☐	☐

	FREQUENT	SOMETIMES
Difficulty tracking moving objects	☐	☐
Unusual clumsiness, poor coordination	☐	☐
Difficulty with sports involving good eye-hand coordination	☐	☐
Eye turns in or out	☐	☐
Sees more clearly with one eye than the other	☐	☐
Feels sleepy while reading	☐	☐
Dislikes tasks requiring sustained concentration	☐	☐
Avoids near tasks such as reading	☐	☐
Confuses right and left directions	☐	☐
Becomes restless when working at his/her desk	☐	☐
Tends to lose awareness of surrounding when concentrating	☐	☐
Must “feels” things to see them	☐	☐
Car sickness	☐	☐
Unusual blinking	☐	☐
Unusual eye rubbing	☐	☐
Dry eyes	☐	☐
Watery eyes	☐	☐
Red eyes	☐	☐
Eyes bothered by light	☐	☐
Trouble copying from board to book	☐	☐
Responds better orally than in writing	☐	☐
Erases excessively	☐	☐
Reverses letters and numbers	☐	☐
Mistakes words with similar beginnings	☐	☐