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B E Y O N D T R A D I T I O N A L V I S I O N C A R E

IMPORTANT: The information on this intake form will enable the doctor to ascertain and evaluate your needs most effectively. Please fill out the following as completely as possible and **PLAN 45 MINUTES TO 1 HOUR** for the initial examination. We look forward to meeting you!

INSTRUCTIONS: 1) Using your computer, you may type directly on this form. **PRINT A HARD COPY** in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form and write the information directly in the spaces provided. Fax or mail the completed form to the fax number or address in the upper right-hand corner. **PLEASE** forward any other pertinent records to our office after this form has been submitted.

I. Patient Information

Last name			First		Called by	
Birth date	Month	Day	Year	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street address						
City		State	Zip	E-mail		
Home phone ()				Mobile phone ()		
Work phone ()				Who referred you to us?		

II. Present Situation

Reason for evaluation:
Type here:

Did the problem(s) occur suddenly?
Type here:

Do the problems seem to be related to illness, accident, or other trauma?
Type here:

A small photo is useful for our files. Please bring one with you to the examination OR insert a digital image. For successful e-mailing capacity It must be 150K or less @ 72dpi.

INSERT IMAGE HERE

III. Current Symptoms

	Never	Sometimes	Often	Difficulty with:	Never	Sometimes	Often
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tunnel vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maintaining attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judging space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment on any long term problems during school years or in past history. (Example: couldn't spell or understand geometry)
Type here:

IV. Visual History

Do you experience problems with:	Yes	Sometimes	No		Yes	Sometimes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision (far)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision (near)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Using the computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doing hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Participating in competitive sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity when driving in bright sunlight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wearing sports goggles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been noticing:

Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting too close to the TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive blinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When you read or write do you:

	Yes	Sometimes	No	Do you:	Yes	Sometimes	No
Reverse letters or numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Close or cover one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transpose words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tilt or turn head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip or repeat words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distort face muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep place with finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have an awkward posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Move lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Move head excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maintain concentration			
Lose place on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	for a long period of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other information? (example: When and how often do these symptoms occur?)

Type here:

IV. Visual History (continued)

Have you had any unusual visual attention or care? Yes No Describe: _____

Do you have glasses now? Yes No

Do you wear them? Yes No

If yes, when should you wear them?

When was the last time your lenses were changed?

Do you wear contact lenses? Yes No

What brand are they?

How often do you wear your lenses?

How many hours per day do you wear your lenses?

How often do you change your lenses?

I wear eyewear or contact lenses during these situations:

business/workday glasses contacts

weekend/evening glasses contacts

casual/recreation glasses contacts

social events glasses contacts

outdoor activities glasses contacts

V. Speech - Auditory History

	Yes	No		Yes	No
Is your speech clear?	<input type="checkbox"/>	<input type="checkbox"/>	Do you omit of parts of words	<input type="checkbox"/>	<input type="checkbox"/>
Can you express thoughts clearly?	<input type="checkbox"/>	<input type="checkbox"/>	Do you stutter	<input type="checkbox"/>	<input type="checkbox"/>
Do you turn your head to one side to listen?	<input type="checkbox"/>	<input type="checkbox"/>	Is speech understandable by others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often say "huh"?	<input type="checkbox"/>	<input type="checkbox"/>	Are there any unusual patterns of speech	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to unusual patterns of speech, please describe: _____

What other language(s) are spoken? _____

VI. Medical History

	Yes	No		Yes	No	What are the allergies? Type here:
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	Asthmatic	<input type="checkbox"/>	<input type="checkbox"/>	
Epileptic	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

Signature _____

Date _____

We will ask you to sign this form at your first visit.

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SUBMIT: