

# TENNESSEE VISION THERAPY

The following information will help prepare you for the upcoming appointment at our office. Your timely completion of the attached documents will allow us the needed time to process and review your case in advance. We ask that every page be filled out in its entirety and all pertinent medical records including your last eye exam are returned to our office **at least two business days prior to your scheduled evaluation.**

## What is a Developmental Vision Evaluation?

A Developmental Vision Evaluation includes checking the general health of the eye, visual acuity (20/20), refractive condition for appropriate corrective lenses when needed and all of the visual functions required for reading, writing, learning, sports performance and functioning in life. A developmental vision evaluation helps to pinpoint the precise area(s) of concern as well as the depth of the problem and to determine the best treatment options.

## What tests are performed?

Sensorimotor Testing- measures ocular motility, ocular alignment, and ocular deviation in more than one area of gaze and binocular fusion. It is necessary for detection, assessment, monitoring and guidance for the medical, surgical and optical management of binocular function and motor eye misalignment.

Visual Perceptual Testing- tests the brain's ability to make sense of what the eyes see. It is important for everyday activities such as dressing, eating, writing, and working. When you have a visual processing dysfunction, more cognitive effort is needed for everyday activities.

## How long does testing take?

Testing takes approximately 2 hours and is scheduled in the morning before the eyes and brain are tired from a full day of school or work. We like to do testing at this time so you have eaten a good, high protein meal and are most attentive.

## Who can come to the appointment?

Because full attention is needed, it is very important that you **do not bring any additional family members other than your spouse to the evaluation.** We ask that only the patient or patient and spouse attend. This minimizes distraction and enhances the productivity of the time spent in our office.

## What is my financial policy?

Third parties, such as medical insurance, Medicare and TennCare, severely limit treatment, care options, and the time the Doctor and team can spend with you. Therefore, The Center for Vision Development and Performance Vision Therapy is a fee-for-service facility and payment is due in full at the time of service. The total cost of the Initial Visit is \$275, which includes the evaluation, testing, consultation, and a follow-up summary of the Doctor's findings.

## Will I get the results the same day?

Yes! During your consultation all of the findings will be explained to you and literature will be provided. The recommendations from the Doctor, how to proceed and expectations will also be explained.

Tennessee Vision Therapy Group  
3252 Aspen Grove Drive, Suite 7  
P: 615-791-5766 or 615-905-4668  
[info@tnvisiontherapy.com](mailto:info@tnvisiontherapy.com)

# Over 18 Adult History Form

**Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.**

Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male or Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Are you currently enrolled in School? Yes  No   
Name of School: \_\_\_\_\_ Area of Study: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

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## HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business \_\_\_\_\_  
Internet: Which terms did you search? \_\_\_\_\_  
Current/Previous Patient: \_\_\_\_\_  
Facebook Instagram LinkedIn Driving By

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## EMERGENCY CONTACT INFORMATION

Emergency Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Email: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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## MEDICAL HISTORY: *Please fully complete*

Medical Doctor's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Current Medications (include vitamins/supplements): \_\_\_\_\_

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Are you allergic to any medications? If yes, please list or circle **No Know Drug Allergies**

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Tobacco use? Yes No Packs/day: \_\_\_\_\_ Narcotic use? Yes No  
Alcohol use? Yes No Drinks/day: \_\_\_\_\_

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**Please indicate if you have or had any problems with any of the following.**

Event/Condition	Yes/No	Please describe, including time of onset.
Constitutional Symptoms (e.g. fever, weight loss)		
Hematologic/Bleeding Disorder		
Allergies/Immunologic Disorder		
Endocrine		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
ENT or Vestibular		
Gastrointestinal		
Skin Disorders		
Musculoskeletal		
Genitourinary		

**HAVE YOU EVER EXPERIENCED- check all that apply**

Motor Vehicle Accident	Been Physically Assaulted	Oxygen Deprived at Birth or anytime	Abnormal MRI or CT Scan
Whiplash	Blunt Force Trauma	Any Injury at Birth	Lyme, Measles, Shingles
Motorsports Accident	Victim of Domestic Violence	Brain Tumor, Aneurysm, hemorrhage	Vestibular (dizziness, balance, tinnitus)
Skull Fracture	Slip & Fall Head Injury	Stroke or TIA	Bicycle Accident
Played contact sports in school	Work Related Injury	Epilepsy or Seizures	Drug or Alcohol Overdose

Explain: \_\_\_\_\_

\_\_\_\_\_

List any major illnesses, injuries, surgeries, or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

# Over 18 Adult History Form

## VISUAL HISTORY

Has there been previous vision care? Yes No Date of Last Visit: \_\_\_\_\_

Eye Doctor's Name: \_\_\_\_\_ (Please have these records faxed to our office)

Practice Name: \_\_\_\_\_

Do you have glasses now? Yes No Do you wear them? Yes No  
If yes, when should you wear them? \_\_\_\_\_

Do you wear contact lenses? Yes No If yes, brand and powers: \_\_\_\_\_

Do you have any of the following eye conditions? (Please circle all that apply) Glaucoma Blindness  
Amblyopia/Lazy eye Strabismus/Crossed Eye Cataracts Macular Degeneration

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### Do you notice any of the following?

Please check all that apply

- |   |   |
|---|---|
| <input type="checkbox"/> Blurred vision in the distance or near       | <input type="checkbox"/> Motion sickness  |
| <input type="checkbox"/> Difficulty focusing near/far                 | <input type="checkbox"/> Light or noise sensitivity   |
| <input type="checkbox"/> Eyestrain, fatigue, headaches                | <input type="checkbox"/> Flashes of Light   |
| <input type="checkbox"/> Frowns/squints or has facial tension         | <input type="checkbox"/> Sensory issues   |
| <input type="checkbox"/> Reduced reading comprehension/retention      | <input type="checkbox"/> Difficulty driving (morning or night)                                      |
| <input type="checkbox"/> Skip words or loses place when reading       | <input type="checkbox"/> Can't tolerate visually busy places  |
| <input type="checkbox"/> Slow reader                                  | <input type="checkbox"/> Auditory Learner   |
| <input type="checkbox"/> Confuses letters or words                    | <input type="checkbox"/> Moves lips when reading silently   |
| <input type="checkbox"/> Eye turn, lazy eye, wandering eye            | <input type="checkbox"/> Vocalizes or moves lips when others talk                                   |
| <input type="checkbox"/> Double vision                                | <input type="checkbox"/> Difficulty following verbal instructions                                   |
| <input type="checkbox"/> Cover/close one eye when reading/writing     | <input type="checkbox"/> Poor time management, always late  |
| <input type="checkbox"/> Tilt or turns head to see                    | <input type="checkbox"/> Short attention span or distractible                                       |
| <input type="checkbox"/> Letters or lines float, run together or jump | <input type="checkbox"/> Difficulty attending to detail   |
| <input type="checkbox"/> Difficulty or pain with eye movements        | <input type="checkbox"/> Anxiety  |
| <input type="checkbox"/> Restricted field of vision (peripheral)      | <input type="checkbox"/> Extreme stress   |
| <input type="checkbox"/> Tunnel Vision                                | <input type="checkbox"/> Visual changes due to weather changes                                      |
| <input type="checkbox"/> Difficulty recalling information             | <input type="checkbox"/> Visual changes after eating  |
| <input type="checkbox"/> Loss of long or short term memory            | <input type="checkbox"/> Visual changes <b>only</b> after prolonged computer or cell phone use      |
| <input type="checkbox"/> Poor eye-hand coordination                   | <input type="checkbox"/> Visual changes when getting up too quickly from laying/sitting to standing |
| <input type="checkbox"/> Clumsy, accident-prone                       | <input type="checkbox"/> Visual changes after rosacea flare up                                      |
| <input type="checkbox"/> Difficulty judging distances or objects      | <input type="checkbox"/> Visual changes started after new medication                                |
| <input type="checkbox"/> Poor Depth Perception (3D movie, parking)    |   |
| <input type="checkbox"/> Difficulty with navigation or direction      |   |
| <input type="checkbox"/> Hearing loss and/or ringing in the ears      |   |
| <input type="checkbox"/> Dizziness or loss of balance                 |   |
| <input type="checkbox"/> Disorientation                               |   |

Other: \_\_\_\_\_

# Over 18 Adult History Form

## SPECIALISTS (must be completed)

**Neurologist:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Psychologist/Psychiatrist:**     Yes    No    Currently in treatment?    Yes    No  
Tester Name & Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Occupational Therapist:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Speech Therapist:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Physical Therapist:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Audiologist/Vestibular Rehab:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Physiatrist:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Chiropractor:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Naturopathic Doctor:**     Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

**Infectious Disease/Internal Medicine:**    Yes    No    Currently in treatment?    Yes    No  
Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Facility Name & Address: \_\_\_\_\_

# Over 18 Adult History Form

## SCREEN TIME

Average screen time per day (TV, tablets, computers, phones, etc.): \_\_\_\_\_

How do your eyes feel after working on the computer? \_\_\_\_\_

Where is the top of the screen located (circle): above eye level at eye level below eye level

What is the distance from your eyes to the screen? \_\_\_\_ To your source document? \_\_\_\_\_

Where is the computer screen located (circle): directly in front to your right to your left flat  
(horizontal) vertical multiple screens

Do you experience any of the following in your work area (circle)? Glare Reflections

Difficulty Reading Difficulty changing focus after computer use

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## GENERAL BEHAVIOR

Any challenges at work/school/home? If so, what are they and are there specific triggers?

Any traumatic life events? (separation/divorce, loss of family member, military, major illness)

What best describes your activity level?  Inactive  Moderate  Extreme

Do you use a wheelchair? Yes No Can you sit in an examination chair? Yes No

Any pending lawsuits due to injury? Yes No Firm representing you: \_\_\_\_\_

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## SLEEP HABITS

How many hours of sleep do you get each night? \_\_\_\_\_ What time do you go to bed? \_\_\_\_\_

Do you sleep through the night?  Yes  No Do you use any sleep aids?  Yes  No

Have you been diagnosed with sleep apnea?  Yes  No Age at diagnosis? \_\_\_\_\_

Do you/you child use CPAP/BiPAP?  Yes  No

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I hereby give my permission to Tennessee Vision Therapy to treat:

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient, Parent, or Guardian's Signature

\_\_\_\_\_  
Date

# Over 18 Adult History Form

## Release of information:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care, with your permission. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my examination records to be forwarded to myself or other health care providers upon their written request or upon recommendation of Tennessee Vision Therapy when it is necessary for the treatment of my visual condition. I authorize Tennessee Vision Therapy, and/or their staff to exchange information with other professionals involved in my care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

## Release of Information to Non-Medical Staff/Family Members

I, \_\_\_\_\_, give permission for Tennessee Vision Therapy to release medical information to the following non-medical individual(s)- teachers, tutors, coaches.

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient