

TENNESSEE VISION THERAPY

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

Patient's Full Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Gender: Male or Female
Address: _____ City: _____ Zip: _____
Cell: _____ Email: _____
Name of School: _____ Grade: _____

HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business _____
Internet: Which terms did you search? Vision Therapy Lazy Eye Crossed Eye ADHD
Learning Disabilities Convergence Autism Tracking Issues Reading Issues
Current/Previous Patient: _____

CONTACT INFORMATION

Mother/Caretaker's Name: _____ Cell: _____
Email: _____ Work Phone: _____
Father/Caretaker's Name: _____ Cell: _____
Email: _____ Work Phone: _____

Sport #1 _____ # of hours playing sport(s) each day _____
Team/Club Info _____
Coach/Athletic Trainer(s) _____

Sport #2 _____ # of hours playing sport(s) each day _____
Team/Club Info _____
Coach/Athletic Trainer(s) _____

Sport #3 _____ # of hours playing sport(s) each day _____
Team/Club Info _____
Coach/Athletic Trainer(s) _____

Your Child's Medical History: *Please fully complete*

Pediatrician: _____ Date of Last Visit: _____

Current Medications (include vitamins/supplements): _____

Is your child allergic to any medications or medical preservatives? **No Know Drug Allergies**

Have you had a sports injury in the last year? No Yes If yes, please explain:

Have you had a concussion? No Yes If yes, how many, when and how:

List illnesses, bad falls, high fevers, car accident, etc. _____

Your Medical History:

Review of Systems	List symptoms, diagnosis, surgeries, or hospitalization
Any new symptoms- fever, weight loss, night sweats, fatigue, etc.	
Hematologic- anemia, excessive bleeding, etc.	
Allergies/Immunology- swollen lymph nodes, anaphylaxis, etc.	
Endocrine- diabetes, thyroid, hormonal, etc.	
Psychiatric- depression, anxiety, etc.	
Neurological- numbness, weakening, paralysis, etc.	
Heart Problems- Chest pain, irregular heartbeat, high blood pressure, murmur, etc	
Respiratory- short, shallow, or increased breathing, wheezing, etc	
Ears/Nose/Throat- Sinus, hearing loss, etc.	
Gastrointestinal- Reflux, digestive or bowel issues, etc	
Skin Disorders- rashes, dryness, cracking, etc.	
Musculoskeletal- arthritis, joint pain, swelling, etc.	
Genitourinary- pain, discomfort, red urine, etc	

YOUR VISUAL HISTORY:

Date of last eye exam _____ Name of eye doctor _____

Reason for exam, results, & recommendations: _____

Do you wear glasses for driving, sports, television, computer, reading? (please circle)

Age of first spectacle _____

Do you feel glasses or contacts are ideal for your sport? Yes No If not, please explain:

If you wear contacts, what kind? _____ Hours of wearing time? _____

If you do not wear contacts, are you interested in wearing them? Yes No

Any eye injuries or eye surgeries? When and describe: _____

Do you feel your vision is affecting your sports performance? No Yes Describe: _____

PRESENT SITUATION:

Do you experience any of the following?

1. Intermittent blurry vision at distance /near (please circle) Yes No

2. Red / Burning eyes Yes No

3. Itchy / Watery eyes (please circle one) Yes No

4. Eyes Strain / Tired Yes No

5. Headaches around forehead, temple or eyes Yes No

6. Nausea associated with visual tasks Yes No

7. Starburst or halos around lights Yes No

8. Double vision at distance / near (please circle) Yes No

9. Squinting, covering or closing one eye Yes No

10. Sensitivity to light / lighting / glare (please circle) Yes No If yes, when?

SPORTS:

What position(s) do you play? _____

What hand do you throw with? R L Both Which way do you bat/swing? R L Switch n/a

Which foot do you kick with? R L Both Which eye do you sight with? R L

Do you have any visual plan when or before you compete? Yes No

Do you do any visual warm up activities? Yes No

Do you have any problems with balance? Yes No

Is your overall sports performance as consistent as you would like? Yes No

Is the level of your performance consistent throughout a game? Yes No

Does your performance decrease under pressure? Yes No

Does your performance increase under pressure? Yes No

Does any of the following interfere with or affect your performance? (Check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> bright sun | <input type="checkbox"/> busy background | <input type="checkbox"/> rain |
| <input type="checkbox"/> dim light | <input type="checkbox"/> crowd movement | <input type="checkbox"/> uniform color |
| <input type="checkbox"/> without sunglasses | <input type="checkbox"/> player movement | <input type="checkbox"/> player chatter |
| <input type="checkbox"/> with sunglasses | <input type="checkbox"/> crowd noise | <input type="checkbox"/> indoor vs outdoor |

Do you feel you are playing to your potential? Yes No If not, please describe: _____

What areas would you like to improve?

- | | | |
|--|---|---|
| <input type="checkbox"/> Tracking | <input type="checkbox"/> Depth Perception | <input type="checkbox"/> Consistent Performance |
| <input type="checkbox"/> Visualization | <input type="checkbox"/> Attentional Focus | <input type="checkbox"/> Eye-Hand Coordination |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Peripheral Awareness | <input type="checkbox"/> Judging Speed |
| <input type="checkbox"/> Reaction Time | <input type="checkbox"/> Judging Distance | <input type="checkbox"/> Decreasing Distractibility |

If not listed above, list any specific areas you would like to improve in your game: _____

Patient/Parent Signature: _____ Date: _____