Dr. Rob Lauver, III OD, FCOVD

717-687-8141

Behavioral Questionnaire For Neuro-Optometric Rehabilitation

Name:_____Date:_____

Birthdate:_____Brain Injury Date:_____

Please check the signs and symptoms that best describe how you feel or are performing

FOCUSING DEFICIENCIES:

- ☐ Blurry or fluctuating near vision
- ☐ Blurry distance vision
- ☐ Blurry distance vision *after* near work
- ☐ Eye fatigue after short period of reading or near work
- ☐ Holds book too closely
- ☐ Has difficulty sustaining near tasks
- ☐ Has red eyes
- ☐ Avoids near visual tasks
- ☐ Eyes hurt, burn, or tire while reading or doing near work
- ☐ Headaches with near work
- ☐ Excessive rubbing, blinking, or tearing of eyes

EYE POINTING DEFICIENCIES:

- ☐ Reports eye strain with reading, writing or near work
- ☐ Reports frontal headaches associated with visual tasks
- ☐ Squints, closes, or covers one eye during visual tasks
- ☐ Reports that letters, words, or both appear to float, jump, or move around on the page
- ☐ Has abnormal posture when doing near visual tasks (tilting head or body)
- ☐ Intermittent double vision
- ☐ Can’t figure out where to look through spectacle bifocals

EYE MOVEMENT DEFICIENCIES:

- ☐ Excessive head movement when reading
- ☐ Frequent loss of place when reading
- ☐ Omission of small words or skipping of lines when reading
- ☐ Use of a finger or marker when reading
- ☐ Lack of comprehension when reading
- ☐ Re-reads lines unknowingly

Any section with 3 or more checked or a total of 5 or more checked indicates a need for binocular vision evaluation.

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VISUAL-SPATIAL DEFICIENCIES:

- ☐ The world seems to be unstable
- ☐ The floor or walls appear to be tilted
- ☐ Lack of coordination and balance
- ☐ Clumsy; falls and bumps into things often
- ☐ Tendency to work with one side of the body while the other side doesn't participate
- ☐ Tendency to drift to one side while walking or while steering
- ☐ Knocks over objects or misses objects while reaching for them
- ☐ Inaccuracy with keys in locks or touching buttons
- ☐ Dizziness
- ☐ Motion Sickness
- ☐ Consistently leans or turns to one side

VISUAL-ANALYSIS DEFICIENCIES:

- ☐ Has trouble telling time on a clock with minute and hour hands
- ☐ Confuses likenesses and minor differences
- ☐ No longer recognizes familiar written words
- ☐ Mistakes words with similar beginnings
- ☐ Difficulty recognizing the same word repeated on a page
- ☐ Difficulty recognizing letters or simple forms
- ☐ Difficulty distinguishing the main idea from insignificant details
- ☐ Has trouble writing and remembering letters and numbers

VISUAL FIELD DEFICIENCIES:

- ☐ Can't find objects to one side
- ☐ Bumps into objects on one side
- ☐ Is surprised by objects or people that seem to pop into view
- ☐ Only eats food on one side of plate
- ☐ Ignores space on one side of the room
- ☐ Says they can't see out of one eye

SENSORY INTEGRATION DEFICIENCIES:

- ☐ Can only do one thing at a time
- ☐ Doesn't notice peripheral objects while concentrating visually on something
- ☐ Can't carry on an intelligent conversation while doing some motor task
- ☐ Has trouble multi-tasking
- ☐ Thinking speed is slower

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Head Trauma Case History

Name: _____ DOB:_____ Age: _____ Date: _____
Address: _____ City:_____, State: _____ Zip:_____
SSN:_____ Referred by: _____
Current Medications:
_____
_____
Allergies: _____

1. Date of Accident/Surgery/Trauma: _____
2. Describe the accident/surgery/Trauma:
   _____
   _____
   _____
   _____
3. Number of previous Head traumas: _____ dates: _____
4. Drug abuse; poising Type: _____
5. Vascular Event: Type (Stroke, aneurysm): _____
6. Other: _____ DATE: _____
7. What part of your head was affected: (Circle)
   Forehead Right Side Top of Head Face Back of head Let side

   Were you unconscious? Yes / No If yes, for how long: _____
   Comments: _____
8. Initial Care
   a. Did you see a doctor? Yes / No ; When: _____
   b. Whom did you see?: _____
   c. Where?: _____
   d. What were you or your family told?: _____
   e. Comments:
      _____
      _____
9. Other Professional Care
   What kind of professional care for your injuries/trauma have you received or are receiving?
   Family Physician: _____ ER Doctor: _____
   Chiropractor: _____ Occupational Therapist: _____
   Neurologist: _____ Physical Therapist: _____
   Neuropsychologist: _____ Speech Therapist: _____
   Audiologist:_____ Physiatrist:_____
   Psychologist:_____ Psychiatrist: _____
   Optometrist: _____ Ophthalmologist: _____
   Osteopath: _____ Massage Therapist: _____
   Other: _____

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10. Symptoms immediately following the accident
    _____ Double Vision _____ Headache _____ Loss of Memory _____ Blurred vision
    _____ Pain In or Around Eyes _____Vomiting _____ Dizziness _____ Restrictive Field of View
    _____ Loss of Balance _____ Disorientation _____ Flashes of Light _____ Restricted Motion
    Comments: _____
    _____
    _____
11. Difficulties Following the Accident
    a. Work Related, Please Describe:
       _____
       _____
    b. Hobbies/Avocational, Please Describe: _____
       _____
    c. Recreational/Social, Please Describe: _____
       _____
    d. Other: _____
       _____

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