Vision Transformation, Inc. 2535 S Lewis Way Suite 209 Lakewood CO 80227. 303-865-4290

Name:	Age:	Birthdate:	Date:
In What way is vision bothering you? What is your main reason for this appointment?			
When was your last vision examination?	Name of Provider:		
Tell us about the work you do / did: (If you are a student tell us about that; What Grade are you in?)			
Please tell us about your injury:		Date of Injury:	

Please help us distinguish symptoms as they relate to injury.

If you are not injured fill out only the current column.

Mark any symptoms / conditions you have and Add comments

0=not a problem 1 =problem is mild or infrequent 2= problem is occasional or moderately severe

3= problem is frequent and/or severe 4= problem is severe and/or constant

	Before Injury	Right Away After Injury	Currently
Blur in the distance wearing your best glasses	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Blur at near wearing your best glasses	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Headache: Where on head?_____	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
How frequent are headaches? _____Describe them: _____			
Eye fatigue	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyes ache	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyes burn	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyes itch	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eye redness	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyes feel dry	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyes water	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Dizziness, nausea, disorientation	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Double Vision	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Floor looks like it is moving	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Words move or jumble on the page	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Fall asleep when reading	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Loss of place when reading	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

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	Before Injury	Right Away After Injury	Currently
Sensitive to light	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Sensitive to sound/Ringing in the ears/Changes in hearing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Poor night Vision	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Eyelid problems	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Difficulty throwing a ball	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Difficulty catching a ball	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Trouble tracking a moving object	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Discomfort in crowds	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Poor handwriting	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Avoid certain academic tasks _____	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Emotional response to visual tasks / academics	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Poor ability to concentrate	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Poor ability to multi-task	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Poor ability to disengage from a task I am involved in	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Easily distracted by the things going on around me	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
It seems like tasks take longer than they should	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Lose track of time	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Body pain: _____	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Memory issues	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Flashes of light	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Floaters	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
See trails or persistent images	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

Eye Surgeries: _____

Other: _____

Circle any that apply: Diabetes / hypoglycemia / Heart Problems / circulatory conditions / Skin conditions

What medications are you taking? _____

What providers are you seeing? _____

Signature is required: _____