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The Mackowsky Visual Learning & Rehabilitation Clinic

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Traumatic Brain Injury/Concussion Intake Form

IMPORTANT: Please fill out this questionnaire in black ink & bring with you to your appointment. The information on this form will enable Dr. Mackowsky to ascertain & evaluate your needs most effectively. Also, to assist us with your appointment, we would like to review your current & past medical records including MRI or cat scan results, therapy reports, neurological reports etc. prior to seeing you. Please include recent & past vision records. These will be useful in planning your care & avoiding unnecessary duplication of testing. Please email or fax these records if possible before your appointment. Thank you & we look forward to meeting you.

I. PATIENT Information

Today's Date: ___/_____/_____

Patient's Full Name:_____DOB:__/__/___AGE:_____☐Male ☐ Female

Parent's Names (if child): _____

Address:_____City_____State:_____Zip Code:_____

Home Phone: _____Work/Cell Phone: _____Medical Dr:_____Phone #:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced E-Mail:_____

Medical Insurance Co.: _____ID #:_____Grp #:_____

Name of Policy Holder:_____Co-pay for In-Network Office:regular $_/specialist $_____

Policyholder's Place of Employment:_____Policyholder's Job Title:_____

Policyholder's Birthdate:___/___/___Yearly Deductible met? Y/N If Medicare, name of supplemental: _____

HSA insurance acct?_____High Deductible ($1000 or more)? Y/N Referred by:_____

II. INJURY History

Date/Time of Injury:_____Injury description:_____

_____

_____

Location of Impact: On the head- ☐Front ☐Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Back or Other location: ☐ Neck ☐ Body

Cause: ☐ Car accident ☐ Hit by a car ☐ Fall Assault ☐ Sports (specify)_____Other _____

Are there any events just BEFORE the injury that you have no memory of (even brief)? ☐Yes ☐No Duration_____

Are there any events just AFTER the injury that you have no memory of (even brief)? ☐Yes ☐No Duration_____

Did you lose consciousness? ☐Yes ☐No Duration:_____

Early Signs: ☐Dazed or stunned ☐Confused about events ☐Slow to respond ☐Dizzy ☐Forgetful ☐Repeating things

Were seizures observed? ☐Yes ☐No If yes, please provide details:_____

Did you receive medicalattention atthe time of the injury? ☐Yes ☐No If yes, please explain, including any tests & results:

_____

_____

Since the injury, have you experienced any of these symptoms more than usual?
Please use the following scale to rate each symptom: None Mild Moderate Severe
0 1 2 3 4 5 6

___Headache	___Dizziness	___Sleeping more than usual	___Attention difficulty	___Motion sensitivity
___Nausea	___Lightheadedness	___Sleeping less than usual	___Feeling slowed down	___Ruminating thoughts
___Vomiting	___Balance problems	___Drowsiness	___Sadness/hopelessness	___Difficulty in Math
___Sensitivity to light	___Numbness/tingling	___Difficulty concentrating	___Nervous/anxious	___Difficulty reading
___Sensitivity to noise	___Fatigue	___Feeling mentally foggy	___Irritability	___Symptoms worse
___Visual Problems	___Trouble falling asleep	___Difficulty remembering	___More emotional	at end of day

Has anything like this ever happened in the past? ☐Yes ☐No

If yes, how many times? 1 2 3 4 5 6+

What's the longest you experienced symptoms? ☐ Days ☐Weeks ☐Months ☐Years

Has there been any prior treatment for headaches? ☐Yes ☐No Any history of migraines? ☐ Personal☐ Family

Is there a history of Learning Disability? ☐Yes ☐No; ADD/ADHD? ☐Yes ☐No; Other Developmental Disorder?_____

Is there a history of Anxiety? ☐Yes ☐No; Depression? ☐Yes ☐No; Sleep Disorder? ☐Yes ☐No;
Other?_____

Is there a pending lawsuit? ☐Yes ☐No; Name of Law firm representing you:_____

Please rate your average pain on a symptom scale of 0-10 (0 equals no pain and 10 equals worst imaginable):_____

Rate how near you are to your normal function on a scale of 0-10 (0 equals not able to perform any of your normal activities & 10 equals able to do all normal activities without difficulty):_____

III. DIZZY History (please SKIP to section IV if no symptoms of dizzy)

Do you experience a false sense of motion that you are moving? ☐Yes ☐No If yes, in which direction:_____

Do you experience a false sense of motion that the world is moving? ☐Yes ☐No If yes, in which direction:_____

Are your dizziness symptoms ☐ Recent (1st episode) ☐ Reoccurring ☐ Chronic

What is the typical duration of your symptoms? ☐ Secs ☐ Several secs to a few mins ☐ Mins to one hour ☐ Days ☐ Weeks

Do you have hearing loss? ☐Yes ☐No

Do you have ringing in your ears? ☐Yes ☐No

Is there any correlation with timing of your symptoms and taking a new medication? ☐Yes ☐No ☐Maybe

Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins? ☐Yes ☐No

Can your symptoms of dizziness be reduced by visually fixating on a target? ☐Yes ☐No

Are there any other symptoms you experience besides dizziness? ☐Yes ☐No What? (ex. Nausea, anxiety, racing heart, etc.)

Is there anything that can aggravate your dizziness? ☐Yes ☐No What?_____

Does anything help your symptoms? ☐Yes ☐No What?_____

Do any of the following movements cause you to feel disoriented or dizzy?

- Turning to the right? ☐Yes ☐No
- Turning to the left? ☐Yes ☐No
- Suddenly stopping in a car or a plane landing ☐Yes ☐No
- Moving side to side? ☐Yes ☐No
- Suddenly moving up or down on an elevator? ☐Yes ☐No
- Suddenly stopping in a car or a plane landing ☐Yes ☐No

Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear? ☐Yes ☐No

Did your dizziness start after heavy weight bearing or excessive straining with bowel movements? ☐Yes ☐No

Can sneezing, straining or changes of pressure trigger your dizziness? ☐Yes ☐No

Can putting your head down to one side trigger your dizziness?	☐Yes ☐No
Can loud noises or sounds at times trigger your dizziness?	☐Yes ☐No
Have you started to notice your own voice much louder than before?	☐Yes ☐No
Have you noticed any distortions of sensations of sound?	☐Yes ☐No
Can positional changes such as turning over in bed, bending over and then straightening up or tilting your head trigger your symptoms?	☐Yes ☐No
Are your symptoms or dizziness prompted by eye or head movements and then decrease in less than one minute?	☐Yes ☐No
Does your dizziness become less noticeable each time you repeat the same movement?	☐Yes ☐No
Do your episodes of dizziness come in sudden and brief spells?	☐Yes ☐No
Did your dizziness come on suddenly?	☐Yes ☐No
Did your dizziness start after a recent viral or bacterial infection?	☐Yes ☐No
Do you have a history of herpes zoster outbreaks?	☐Yes ☐No
Did your dizziness start during a period of exhaustion or weakened immune system?	☐Yes ☐No
Do you notice a feeling of fullness in the air or on the side of your head accompanying your episodes of dizziness?	☐Yes ☐No
Do you have episodes of ringing in your ear accompanying your episodes of dizziness?	☐Yes ☐No
Have you experienced two or more episodes of vertigo lasting at least 20 minutes each?	☐Yes ☐No
Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches?	☐Yes ☐No
Do you experience a throbbing headache before or after your episodes of dizziness?	☐Yes ☐No
Do you become extremely sensitive to light and sound before or after your episodes of dizziness?	☐Yes ☐No
Have you noticed our your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG?	☐Yes ☐No

Have you ever been diagnosed or suffered from any of the following conditions (please check all that apply)?

☐Benign paroxysmal positional vertigo ☐Meniere's disease ☐Otoxicity ☐Otosclerosis ☐Tinnitus
☐Superior canal dehiscence ☐Acoustic neuroma ☐Stroke ☐Migraine ☐Hearing Loss
☐Transient ischemic attack ☐Peri lymphatic fistula ☐Vestibulopathy ☐Cerebellum disease ☐Neurotoxicity
☐Autoimmune inner ear disease ☐Cervicogenic syndrome ☐Cholesteatoma ☐Mal de Barquement ☐Concussion
☐Vestibular neuronitis or labyrinthitis ☐Endolymphatic hydrops ☐Trauma to ear ☐Trauma to head/brain
☐Enlarged vestibular aqueduct

IV. VISION History

Has there been previous vision care? ☐Yes ☐No If yes, date of last exam: ____/____/____

Name of Eye Doctor: _____ (Please have these records faxed to our office)

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: _____

How do you wear your contact lenses (please check all that apply): ☐daily wear ☐extended wear ☐non-disposable ☐disposable

Do you have any of the following eye conditions? (Please check all that apply)

□ Glaucoma □ Blindness □ Amblyopia/lazy eye Other:_____
□ Strabismus/crossed eye □ Cataracts □ Macular Degeneration

Is there a family history of any of the following eye conditions? (Please check all that apply)

□ Glaucoma ☐ Blindness ☐ Amblyopia/lazy eye Other:_____

□ Strabismus/crossed eye ☐ Cataracts ☐ Macular Degeneration

List all eye medications you take: _____

V. SPEECH/AUDITORY History

Is your speech clear? ☐Yes ☐No Do you omit parts of words when speaking? ☐Yes ☐No

Can you express thoughts clearly? ☐Yes ☐No Is speech understandable by others? ☐Yes ☐No

VI. MEDICAL History

Date of most recent physical:_____/___/___By Whom:_____

Results and recommendations:_____

Do you have any of the following medical conditions? (please check all areas that apply)

□ Diabetes	☐ Thyroid disease	☐ Musculoskeletal (muscles/bones/joints)
□ Hypertension	☐ GI Disease	☐ Ear/Nose/Throat/Mouth
□ Heart Disease	☐ Arthritis	☐ Mental (depression/anxiety)
□ Lung	☐ Kidney/Bladder/Genital	☐ Integument (skin)
□ Emphysema	☐ Neurological	☐ Allergic/Immunologic
□ Asthma	☐ Blood/lymphatic	Other:_____

Is there any family history of medical problems? (please list) _____

Please list all medication currently used (include for what conditions): _____

_____

_____

VII. SURGICAL History

Please list all previous surgeries and dates:

_____

_____

VIII. SOCIAL History

Tobacco use? ☐Yes ☐No Packs/day:_____ Narcotic use? ☐Yes ☐No

Alcohol use? ☐Yes ☐No Drinks/day:_____ Sexually transmitted Disease? ☐Yes ☐No _____

IX. THERAPY Treatment (eg. Physical Therapy, Occupational Therapy, Speech Therapy, etc.)

Therapist Names:_____

Facility Names:_____

Reason:_____

Types of Treatment:_____

Dates of Treatment:_____

Are you currently in therapy? ☐Yes ☐No Case Manager (if applicable): _____

Phone #:_____ Email Address:_____

X. GOALS

Please list what your goals are for coming to our office:_____

_____

XI. ADDITIONAL Information (for adults only)

Do you live alone? ☐Yes ☐No

If not, name and relationship of person who lives with you: _____Relationship _____

Do you have an employed in-home "caretaker? ☐Yes ☐No Caretaker's Name: _____

Who will accompany you to my office? _____

XII. WORK/SCHOOL History

Occupation or grade level (if a student)_____

Name of Employment/School _____

City_____State_____Zip_____

Please list job duties _____

Current Status? □ Full duty □ Temporary disability □ Permanent disability □ Applied or applying for disability

□ Retired □ Volunteer □ Light duty □ Modified duty/job restrictions are: _____

Do you feel you are able to work/go back to school:☐Yes ☐No Please state why or why not:_____

_____

Anticipated return to work/school date? _____

XIII. COMPUTER Use

Do you have a computer? ☐Yes ☐No (if yes, please continue to answer all questions in the computer section)

Do you have internet access: ☐Yes ☐No

How many hours do you spend in front of a computer screen each day?_____

How do your eyes feel after working on the computer? _____

Where is the top of the screen located (please check): ☐ above eye level ☐ at eye level ☐ below eye level

What is the distance from: Your eyes to the screen?_____
Your eyes to the keyboard?_____
Your eyes to your source document? _____

Where is the computer screen located (please check):
□ directly in front of you when seated ☐ to your right ☐ to your left ☐ flat (horizontal) ☐vertical

Do you experience any of the following in your work area (please check)?

□ Glare ☐ Reflections ☐Difficulty reading source documents

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

XIV. INSURANCE Filing and Release of Information

Dr. Mackowsky uses photos and videos during her examination to evaluate posture/balance/visual spatial awareness. Your signature below gives her permission to photograph and video tape (to be used exclusively in the office) to determine the best treatment modality for the below patient.

We will file all in-network insurance claims and will provide invoices for you to file out-of-network claims. Your signature below signifies you realize you will be responsible for all copays/deductibles/non-covered services on the date the service is rendered, if you are in-network.

It is also often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Your signature below permits information from, or copies of, your examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Dr. Mackowsky when it is necessary for the treatment of your visual condition, or for the processing of insurance claims. I authorize Dr. Mackowsky to exchange information with other professionals involved in my or my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Patient or Representative Signature _____Date _____

Relationship to Patient (if applicable):_____

Please be on time for your appointment to allow Dr. Mackowsky the full hour for her evaluation. Late arrivals will be rescheduled. We also request a minimum of 48 hours notification to reschedule an existing appointment. Thank you.

Dr. Mackowsky's Signature _____Date _____