

**The Mackowsky
Visual Learning &
Rehabilitation Clinic**

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Traumatic Brain Injury/Concussion/Stroke Intake Form

IMPORTANT: Please fill out this questionnaire in black ink and 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/Stroke: _____ 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 medical attention at the time of the injury? ☐ Yes ☐ No If yes, please explain, including any tests & results: _____

III. Multi-System Symptoms

For each statement below, give a rating (scale of 0-4, 4 being severe) that best reflects how the symptom affects you currently.

Cognition

- I experience brain fog ____
- My thinking feels slowed ____
- I have difficulty remembering ____
- I have difficulty focusing/maintaining attention ____
- Mental activity causes fatigue/cognitive overload ____

Ocular (Vision)

- I experience blurred or double vision ____
- I experience eye strain ____
- I have difficulty reading/visually tracking objects ____
- Visual activities contribute to headaches ____
- I have difficulty judging depth or distance ____

Affective (Emotional Regulation)

- I experience anxiety or panic ____
- I experience depression or persistent low mood ____
- I experience mood swings or irritability ____
- I withdraw from social activities or other people ____
- I have difficulty with motivation ____

Cervical (Neck and Posture)

- I experience neck pain ____
- I experience neck stiffness ____
- My neck feels unstable or difficult to control ____
- I experience headaches or dizziness associated with neck symptoms ____
- I experience posture-related discomfort or difficulty maintaining posture ____

Headache

- I experience migraine-type headaches ____
- I experience tension-type headaches ____
- I experience sensitivity to light ____
- Light or noise triggers or worsens my headaches ____
- Stress/physical exertion worsens headaches ____

Cardiovascular (Autonomic Regulation & Circulation)

- I experience dizziness or lightheadedness ____
- I experience fatigue that limits my daily activities ____
- I experience brain fog along with dizziness/fatigue ____
- I have difficulty tolerating physical exertion ____
- I have difficulty judging depth or distance ____

Vestibular (Balance & Spatial Awareness)

- I experience motion sensitivity ____
- I experience dizziness or nausea ____
- I feel unsteady/have difficulty maintaining balance ____
- My symptoms worsen in busy or visually complex environments ____
- I experience blurry vision or discomfort during car travel or movement ____

Auditory (Sound Processing & Brain Integration)

- I experience sensitivity to sound ____
- I experience ringing or other noises in my ears ____
- I have difficulty processing or understanding spoken information ____
- I feel overwhelmed in noisy environments ____
- I have difficulty judging where sounds come from ____

Autonomics (Nervous System Regulation)

- I have difficulty regulating my body temperature ____
- I experience gastrointestinal or digestive symptoms ____
- I experience disturbed or unrefreshing sleep ____
- I experience persistent or unexplained fatigue. ____
- I notice unusual or uncomfortable changes in my heart rate ____

Activities or situations that worsen symptoms: _____

*Adapted from the COACH CVA2 Clinical Guideline Overview

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 history of Postural Orthostatic Tachycardia Syndrome? ☐ Yes ☐ No

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): _____

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 contacts (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 ☐ Alzheimer's/Dementia
☐ Hypertension ☐ GI Disease ☐ Parkinson's
☐ Heart Disease ☐ Arthritis ☐ Mental (depression/anxiety)
☐ Lung ☐ Kidney/Bladder/Genital ☐ Integument (skin)
☐ Emphysema ☐ Neurological ☐ Allergic/Immunologic
☐ Asthma ☐ Multiple Sclerosis ☐ Ear/Nose/Throat/Mouth
☐ Blood/Lymphatic ☐ Parkinson's ☐ Allergic/Immunologic
☐ Musculoskeletal (muscles/bones/joints) Other: _____

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

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

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:_____

Have you noticed symptom improvement:_____

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 the 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 _____