# The Mackowsky Visual Learning & Rehabilitation Clinic

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# Adult Medical Questionnaire

**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 and evaluate your needs most effectively. Please also forward any other pertinent records to our office prior to this initial visit. Thank you and we look forward to meeting you.

## I. Patient Information

| | | | | |
|---|---|---|---|---|
| Today's Date (MM / DD / YYYY) | Patient's Full Name | | | DOB (MM / DD / YYYY) |
| AGE | Male / Female<br>☐ Male ☐ Female | Parent's Names (if child) | | |
| Address | | City | State | Zip Code |
| Home Phone | Work/Cell Phone | Medical Dr | Phone # | |
| Marital Status<br>☐ Married ☐ Single ☐ Widowed ☐ Divorced | | E-Mail | | |
| Medical Insurance Co. | | ID # | Grp # | |
| Name of Policy Holder | | Co-pay for In-Network Office: regular<br>$ | Co-pay for In-Network Office: specialist<br>$ | |
| Policyholder's Place of Employment | | Policyholder's Job Title | Policyholder's Birthdate (MM / DD / YYYY) | |
| Yearly Deductible met?<br>☐ Yes ☐ No | If Medicare, name of supplemental | | | |
| HSA insurance acct?<br>☐ Yes ☐ No | High Deductible ($1000 or more)?<br>☐ Yes ☐ No | Referred by | | |

## II. Major Concerns/Chief Complaint

| |
|---|
| Please describe the reason for this evaluation (what happened, when, symptoms, current complaints)? |

## III. Occupation

| | | |
|---|---|---|
| Please record occupation | | |
| Name/Address of Employment Place | | |
| City | State | Zip Code |
| Please list job duties | | |

| | |
|---|---|
| Are you currently working: | ☐ YES ☐ NO |
| Do you feel you are able to work: | ☐ YES ☐ NO |

Please state why or why not

Have you applied or are you planning to apply for disability? ☐ YES ☐ NO

## IV. 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.**

| *Circle one number for each statement (4 = severe)* | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **Cognition** | | | | | |
| I experience brain fog | 0 | 1 | 2 | 3 | 4 |
| My thinking feels slowed | 0 | 1 | 2 | 3 | 4 |
| I have difficulty remembering | 0 | 1 | 2 | 3 | 4 |
| I have difficulty focusing/maintaining attention | 0 | 1 | 2 | 3 | 4 |
| Mental activity causes fatigue/cognitive overload | 0 | 1 | 2 | 3 | 4 |
| **Ocular (Vision)** | | | | | |
| I experience blurred or double vision | 0 | 1 | 2 | 3 | 4 |
| I experience eye strain | 0 | 1 | 2 | 3 | 4 |
| I have difficulty reading/visually tracking objects | 0 | 1 | 2 | 3 | 4 |
| Visual activities contribute to headaches | 0 | 1 | 2 | 3 | 4 |
| I have difficulty judging depth or distance | 0 | 1 | 2 | 3 | 4 |
| **Affective (Emotional Regulation)** | | | | | |
| I experience anxiety or panic | 0 | 1 | 2 | 3 | 4 |
| I experience depression or persistent low mood | 0 | 1 | 2 | 3 | 4 |
| I experience mood swings or irritability | 0 | 1 | 2 | 3 | 4 |
| I withdraw from social activities or other people | 0 | 1 | 2 | 3 | 4 |
| I have difficulty with motivation | 0 | 1 | 2 | 3 | 4 |
| **Cervical (Neck and Posture)** | | | | | |
| I experience neck pain | 0 | 1 | 2 | 3 | 4 |
| I experience neck stiffness | 0 | 1 | 2 | 3 | 4 |
| My neck feels unstable or difficult to control | 0 | 1 | 2 | 3 | 4 |
| I experience headaches or dizziness associated with neck symptoms | 0 | 1 | 2 | 3 | 4 |
| I experience posture-related discomfort or difficulty maintaining posture | 0 | 1 | 2 | 3 | 4 |
| **Headache** | | | | | |
| I experience migraine-type headaches | 0 | 1 | 2 | 3 | 4 |
| I experience tension-type headaches | 0 | 1 | 2 | 3 | 4 |
| I experience sensitivity to light | 0 | 1 | 2 | 3 | 4 |
| Light or noise triggers or worsens my headaches | 0 | 1 | 2 | 3 | 4 |
| Stress/physical exertion worsens my headaches | 0 | 1 | 2 | 3 | 4 |
| **Cardiovascular (Autonomic Regulation & Circulation)** | | | | | |
| I experience dizziness or lightheadedness | 0 | 1 | 2 | 3 | 4 |
| I experience fatigue that limits my daily activities | 0 | 1 | 2 | 3 | 4 |
| I experience brain fog along with dizziness/fatigue | 0 | 1 | 2 | 3 | 4 |
| I have difficulty tolerating physical exertion | 0 | 1 | 2 | 3 | 4 |
| I have difficulty judging depth or distance | 0 | 1 | 2 | 3 | 4 |

| *Circle one number for each statement (4 = severe)* | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **Vestibular (Balance & Spatial Awareness)** | | | | | |
| I experience motion sensitivity | 0 | 1 | 2 | 3 | 4 |
| I experience dizziness or nausea | 0 | 1 | 2 | 3 | 4 |
| I feel unsteady/have difficulty maintaining balance | 0 | 1 | 2 | 3 | 4 |
| My symptoms worsen in busy or visually complex environments | 0 | 1 | 2 | 3 | 4 |
| I experience blurry vision or discomfort during car travel or movement | 0 | 1 | 2 | 3 | 4 |
| **Auditory (Sound Processing & Brain Integration)** | | | | | |
| I experience sensitivity to sound | 0 | 1 | 2 | 3 | 4 |
| I experience ringing or other noises in my ears | 0 | 1 | 2 | 3 | 4 |
| I have difficulty processing or understanding spoken information | 0 | 1 | 2 | 3 | 4 |
| I feel overwhelmed in noisy environments | 0 | 1 | 2 | 3 | 4 |
| I have difficulty judging where sounds come from | 0 | 1 | 2 | 3 | 4 |
| **Autonomics (Nervous System Regulation)** | | | | | |
| I have difficulty regulating my body temperature | 0 | 1 | 2 | 3 | 4 |
| I experience gastrointestinal or digestive symptoms | 0 | 1 | 2 | 3 | 4 |
| I experience disturbed or unrefreshing sleep | 0 | 1 | 2 | 3 | 4 |
| I experience persistent or unexplained fatigue | 0 | 1 | 2 | 3 | 4 |
| I notice unusual or uncomfortable changes in my heart rate | 0 | 1 | 2 | 3 | 4 |

**Adapted from the COACH CVA2 Clinical Guideline Overview*

Activities or situations that worsen symptoms:

Any other noted symptoms/problems. Please list and include onset/frequency.

Please comment on any long-term problems experienced prior to the problem noted on the first page.

## V. VISION History

Has there been previous vision care? ☐ Yes ☐ No

| If yes, date of last exam (MM / DD / YYYY) | 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:

## VI. 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 |

## VII. MEDICAL History

| Date of most recent physical (MM / DD / YYYY) | 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)

## VIII. SURGICAL History

| Please list all previous surgeries and dates: |
|---|
| |

## IX. SOCIAL History

| | | | |
|---|---|---|---|
| Tobacco use? | ☐ Yes | ☐ No | Packs/day: _____ |
| Narcotic use? | ☐ Yes | ☐ No | |
| Alcohol use? | ☐ Yes | ☐ No | Drinks/day: _____ |
| Sexually transmitted Disease? | ☐ Yes | ☐ No | |

## X. 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 |
|---|---|---|
| | | |

## XI. GOALS

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

## XII. 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? |
| |

## XIII. Additional Information

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? |
|---|
| |

## XIV. COMPUTER

Do you have a computer: (if yes, please continue to answer all questions in the computer section) ☐ YES ☐ NO

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 circle): |
|---|
| above your straight-ahead 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 circle): |
|---|
| directly in front of you when seated / to your right / to your left / flat (horizontal) / vertical |

| Do you experience any of the following at work (please circle)? |
|---|
| glare / reflections / difficulty reading source documents |

Do you use a wheelchair? ☐ YES ☐ NO

Can you sit in an examination chair? ☐ YES ☐ NO

## XV. 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