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 (MM / DD / YYYY)	Patient's Full Name		DOB (MM / DD / YYYY)
AGE	Male / Female ☐ 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 $	Co-pay for In-Network Office: specialist $	
Policyholder's Place of Employment	Policyholder's Job Title	Policyholder's Birthdate (MM / DD / YYYY)	
Yearly Deductible met? ☐ Yes ☐ No	If Medicare, name of supplemental		
HSA insurance acct? ☐ Yes ☐ No	High Deductible ($1000 or more)? ☐ Yes ☐ No	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 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.

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

Circle one number for each statement (4 = severe)	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 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
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:

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?	Specify: _____
Is there a history of Anxiety?	☐ Yes ☐ No

Depression?	☐ Yes ☐ No
Sleep Disorder?	☐ Yes ☐ No
Other?	Specify: _____
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)	Circle: 0 1 2 3 4 5 6 7 8 9 10
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)	Circle: 0 1 2 3 4 5 6 7 8 9 10

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 (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)

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? (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 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.

Signature (please circle: patient/parent/spouse/caretaker) _____ Date _____

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 _____