Accent Eye Care
and Sports • Vision Therapy

Adult VT Questionnaire

Name____ Date of Birth____________________
Employer Name & Address____
Home Phone__________________ Work Phone__________________ Cell Phone___________________

Referred By____ Referral Phone________________
Referral Address____

Entering Complaint / Major Concern

1. Please state your main concerns/problems that you are having:________________________________
____
____

Visual History

1. Has there been previous visual care? **YES / NO** Please describe in detail (include any information about glasses, patching, vision therapy, medication or surgery): _______________________________
____
____

2. Have you noticed any of the following?

Yes	No	
Yes	No	a. Skipping or rereading words/letters or losing place.
Yes	No	b. Blurred vision during reading or writing.
Yes	No	c. Headaches associated with visual tasks.
Yes	No	d. Complications with print running together or jumping around.
Yes	No	e. Sensation of eyes not working together.
Yes	No	f. One eye turns at anytime? Please circle: (in) (out) (up) (down)
Yes	No	g. Unusual fatigue after visual concentration.
Yes	No	h. Pain or soreness around or in the eyes at anytime.
Yes	No	i. Reddened eyes or lids.
Yes	No	j. Excessive tearing of eyes or rubs eyes frequently.
Yes	No	k. Excessive blinking.
Yes	No	l. Frowning, scowling, or squinting with visual tasks.
Yes	No	m. Tilting or turning head while reading.
Yes	No	n. Closing or covering one eye in bright light or during visual tasks.
Yes	No	o. Moving head forward or backward while looking at a distance object.
Yes	No	p. Loss of concentration or uncomfortable when reading or doing close work.
Yes	No	q. Holding a book too close while reading.
Yes	No	r. Reversals when reading (was-saw, on- no) or writing (b for d, p for q).
Yes	No	s. Using a finger as a marker when reading.
Yes	No	t. Transposition of letters or numbers (21 for 12).
Yes	No	u. Poor printing or handwriting.
Yes	No	v. Difficulty in copying from a whiteboard or screen to paper.
Yes	No	w. Double vision.
Yes	No	x. Reading slowly or trouble remembering what you read.

Aleta B. Gong • O.D. • P.C. • F.A.A.O. • F.C.O.V.D.
16020 North 35th Avenue, Suite #2 • Phoenix, Arizona 85053
Phone (602) 547-3255 • Fax (602) 375-9580 • accenteyes.com

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General Health and Behavior

1. Have you ever had a Head Injury? **YES / NO** If yes, When?____
   Describe Injury: ____
   ____
   Surgery? **YES / NO** If yes, please describe ____
   ____

2. Have you ever had ANY history of epilepsy or seizures? **YES / NO** If yes, please indicate the results:
   ____
   ____

3. Have you ever had a neurological evaluation? **YES / NO** If yes, please indicate the results:____________
   ____
   ____

4. Have you ever had a speech and language evaluation/therapy and/or occupational or physical therapy?
   YES / NO If yes, please indicate when and the results: ____________________________________
   ____
   ____

5. Did you ever have any severe childhood illnesses, developmental delays, high fevers, injuries, or physical impairment? **YES / NO** If yes, please explain: ____
   ____
   ____

6. Do you have frequent periods of extreme fatigue (sluggishness, excitability, irritability) or tensional behavior (nail / tongue / lip biting, eye blinking / rubbing, etc.)? **YES / NO** If yes, please describe:
   ____
   ____

7. Is there a family history of: Significant reading, writing, or spelling difficulties? **YES / NO**
   Hyperactivity, attention problems, or speech difficulties? **YES / NO**
   If yes, who? ____

8. What are your special interests (sports, hobbies, etc.)? ____
   ____

Educational Information

1. Did you ever attend remedial or special education services? ____
   If yes, when and for what? ____
   ____

2. Other pertinent information: ____
   ____
   ____

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Authorization to Release Medical Information

I give Accent Eye Care and Aleta B. Gong OD, PC permission to release information to the following people:

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Request to Send Reports

I request Accent Eye Care and Aleta B. Gong OD, PC send a report to the following (there may be a charge for reports):

Would you like a copy of the report? __________

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Name: ____Phone:____________________
Address: ____ City: _______________ Zip: __________

Please sign below, giving Accent Eye Care and Aleta B. Gong OD, PC permission to release information and/or reports to the above persons.

Print Name: ____

Signature: ____ Date: ______________________

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