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The Mackowsky
Visual Learning &
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Traumatic Brain Injury/Concussion 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 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: ____________________

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 Titile: ____________________________

Policyholder's Birthdate: ____/____/_____ **Yearly deductible met? Y/N** If Medicare, name of supplemental:______________________________

HSA insurance acct? ___________ High Deductible ($1000 or more)? Referred by____

II. Injury History

1. Date/Time of Injury: _______________ Injury description: ____

____

____

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

3. Cause: ❒Car accident ❒Hit by a car ❒Fall ❒Assault ❒Sports (specify)____________________ Other ______________________________

4. Are there any events just BEFORE the injury that you have no memory of (even brief)? ❒Yes ❒No Duration__________________

5. Are there any events just AFTER the injury that you have no memory of (even brief)? ❒Yes ❒No Duration____________________

6. Did you lose consciousness? ❒Yes ❒No ❒Duration____

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

8. Were seizures observed? ❒Yes ❒No If yes, please provide details____

9. Did you receive medical attention at the 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?

❒Headache	❒Fatigue	❒Difficulty concentrating	❒Drowsiness	❒Sleeping more than usual
❒Nausea	❒Sensitivity to light	❒Difficulty remembering	❒Trouble falling asleep	❒Sleeping less than usual
❒Vomiting	❒Sensitivity to noise	❒Irritability	❒More emotional	❒Feeling mentally foggy
❒Balance problems	❒Numbness/tingling	❒Dizziness	❒Visual Problems	❒Feeling slowed down

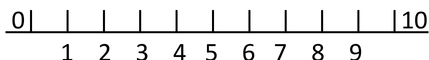
Has anything like this ever happened in the past? YES ❒ NO ❒

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

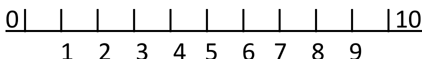
What's the longest you experienced symptoms? ❒ Days ❒Weeks ❒Months ❒Years

Vision	Headache (HA)	Developmental	✔	Psychiatric	✔
History of vision change or disturbance? ❒Y ❒N If yes, please explain: ______ ________________________	Prior treatment for HA? ❒Y ❒ N History of migraine headache ❒ Personal ❒ Family _________________________	Learning disabilities		Anxiety	
		ADD/ADHD		Depression	
		Other Developmental Disorder ___________		Sleep Disorder	
				Other psychiatric disorder	

Rate your **average pain** or symptom on a scale of 0-10 with **"0" equals no pain** and **"10" equals the worst imaginable.**
Mark the line at the point that represents your pain or symptom.



Rate how near you are to your **normal function** on a scale of 0-10 by with **"0" equals not able** to perform ***any*** of your normal activities and **"10" equals able** to do ***all*** normal activities without difficulty. Mark the line at the point that represents your level of function.



Is a law suit pending? **YES** ❒ **NO** ❒

III. 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 now or previously? YES ❒ NO ❒ If yes, brand and powers:_______________________________

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

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

Glaucoma	❒	Blindness	❒	Amblyopia/lazy eye	❒
Strabismus/crossed eye	❒	Cataracts	❒	Macular Degeneration	❒

Other:____

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

Glaucoma	❒	Blindness	❒	Amblyopia/lazy eye	❒
Strabismus/crossed eye	❒	Cataracts	❒	Macular Degeneration	❒

Other:____

List all eye medications you take:____

IV. Speech/Auditory History

	YES	NO		YES	NO
Is your speech clear?	☐	☐	Do you omit parts of words when speaking?	☐	☐
Can you express thoughts clearly?	☐	☐	Is speech understandable by others?	☐	☐

V. Medical History

Date of most recent physical:___________________________ By Whom:____

Results and recommendations:____

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

____

____

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) ____

____

VI. Surgical History

Please list all previous surgeries and dates: ____

____

VII. Social History

	YES	NO			YES	NO	
Tobacco use	☐	☐	Packs/day:_______________	Narcotic use	☐	☐	
Alcohol use	☐	☐	Drinks/day:_______________	Sexually transmitted Disease	☐	☐	______________________

VIII. Current Treatment (eg. Physical Therapy, Occupational Therapy, Speech Therapy, etc.)

By whom ____

Facility Names ____

Reason? ____

Types of Treatment ____

Dates of Treatment ____

Are you currently in therapy? YES ☐ NO ☐

Case Manager (if applicable):____**Phone #:**_____________________________

IX. Goals

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

____

X. 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?____

XI. 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? ____

XII. Computer

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 circle): 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 circle): 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 circle)? Glare / reflections / difficulty reading source documents

Do you use a wheelchair? YES ☐ NO ☐ Can you sit in an examination chair? YES ☐ NO ☐

XIII. Insurance Filing and Release of Information

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 Parent Signature ______________________________________ Date ______________

Relationship to Patient (if applicable):______________________________ 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 ______________