

**The Mackowsky
Visual Learning &
Rehabilitation Clinic**

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Traumatic Brain Injury/Concussion Intake Form

IMPORTANT: Please fill out this questionnaire in black ink & 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: _____ 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: _____

Since the injury, have you experienced any of these symptoms more than usual?

Please use the following scale to rate each symptom: None Mild Moderate Severe
0 1 2 3 4 5 6

___ Headache	___ Dizziness	___ Sleeping more than usual	___ Attention difficulty	___ Motion sensitivity
___ Nausea	___ Lightheadedness	___ Sleeping less than usual	___ Feeling slowed down	___ Ruminating thoughts
___ Vomiting	___ Balance problems	___ Drowsiness	___ Sadness/hopelessness	___ Difficulty in Math
___ Sensitivity to light	___ Numbness/tingling	___ Difficulty concentrating	___ Nervous/anxious	___ Difficulty reading
___ Sensitivity to noise	___ Fatigue	___ Feeling mentally foggy	___ Irritability	___ Symptoms worse at end of day
___ Visual Problems	___ Trouble falling asleep	___ Difficulty remembering	___ More emotional	

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

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 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): _____

III. DIZZY History (please SKIP to section IV if no symptoms of dizzy)

Do you experience a false sense of motion that you are moving? Yes No If yes, in which direction: _____

Do you experience a false sense of motion that the world is moving? Yes No If yes, in which direction: _____

Are your dizziness symptoms Recent (1st episode) Reoccurring Chronic

What is the typical duration of your symptoms? Secs Several secs to a few mins Mins to one hour Days Weeks

Do you have hearing loss? Yes No

Do you have ringing in your ears? Yes No

Is there any correlation with timing of your symptoms and taking a new medication? Yes No Maybe

Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins? Yes No

Can your symptoms of dizziness be reduced by visually fixating on a target? Yes No

Are there any other symptoms you experience besides dizziness? Yes No What? (ex. Nausea, anxiety, racing heart, etc.) _____

Is there anything that can aggravate your dizziness? Yes No What? _____

Does anything help your symptoms? Yes No What? _____

Do any of the following movements cause you to feel disoriented or dizzy?

- Turning to the right? Yes No
- Turning to the left? Yes No
- Suddenly stopping in a car or a plane landing Yes No
- Moving side to side? Yes No
- Suddenly moving up or down on an elevator? Yes No
- Suddenly stopping in a car or a plane landing Yes No

Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear? Yes No

Did your dizziness start after heavy weight bearing or excessive straining with bowel movements? Yes No

Can sneezing, straining or changes of pressure trigger your dizziness? Yes No

- Can putting your head down to one side trigger your dizziness? Yes No
- Can loud noises or sounds at times trigger your dizziness? Yes No
- Have you started to notice your own voice much louder than before? Yes No
- Have you noticed any distortions of sensations of sound? Yes No

- Can positional changes such as turning over in bed, bending over and then straightening up or tilting your head trigger your symptoms? Yes No
- Are your symptoms or dizziness prompted by eye or head movements and then decrease in less than one minute? Yes No
- Does your dizziness become less noticeable each time you repeat the same movement? Yes No
- Do your episodes of dizziness come in sudden and brief spells? Yes No

- Did your dizziness come on suddenly? Yes No
- Did your dizziness start after a recent viral or bacterial infection? Yes No
- Do you have a history of herpes zoster outbreaks? Yes No
- Did your dizziness start during a period of exhaustion or weakened immune system? Yes No

- Do you notice a feeling of fullness in the air or on the side of your head accompanying your episodes of dizziness? Yes No
- Do you have episodes of ringing in your ear accompanying your episodes of dizziness? Yes No
- Have you experienced two or more episodes of vertigo lasting at least 20 minutes each? Yes No

- Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches? Yes No
- Do you experience a throbbing headache before or after your episodes of dizziness? Yes No
- Do you become extremely sensitive to light and sound before or after your episodes of dizziness? Yes No
- Have you noticed our your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG? Yes No

Have you ever been diagnosed or suffered from any of the following conditions (please check all that apply)?

- Benign paroxysmal positional vertigo Meniere's disease Otoxicity Otosclerosis Tinnitus
- Superior canal dehiscence Acoustic neuroma Stroke Migraine Hearing Loss
- Transient ischemic attack Peri lymphatic fistula Vestibulopathy Cerebellum disease Neurotoxicity
- Autoimmune inner ear disease Cervicogenic syndrome Cholesteatoma Mal de Barquement Concussion
- Vestibular neuronitis or labyrinthitis Endolymphatic hydrops Trauma to ear Trauma to head/brain
- Enlarged vestibular aqueduct

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 contact lenses (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 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) _____

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

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: _____
 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 my 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

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 & 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: _____