In Depth Vision Optometry
3262 Fortune Court, Auburn, CA 95602
(530) 830-7007

What is a Neuro-optometric evaluation?

This is a comprehensive evaluation done by an optometrist who is experienced in vision therapy and visual rehabilitation. Dr. Odineal is a board-certified vision therapy/rehab doctor.

Why would I benefit from this?

The eyes are an extension of the brain. When trauma, stroke, or oxygen deprivation occurs to the brain, it usually causes some form of visual dysfunction. The patient may be aware of double vision, eye strain, fatigue, blurred vision or other vision disturbances, or may be totally unaware of problems like visual field loss, visual field neglect, and poor eye teaming, tracking and focusing, and difficulties with dizziness and balance. These deficits can truly create problems with day to day function and can even create risk for the patient and others.

What do I need to do to be seen for this type of evaluation?

Dr. Odineal would like to know in advance about the patients she sees for neuro-evaluations. The testing is scheduled for a longer period of time than for general eye examinations and may be set for two separate visits to the office (depending on how fatigued or dizzy the patient is during the testing). It is very helpful, but not necessary, to have a written referral from a physiatrist, occupational therapist, physical therapist or speech pathologist along with a history of the problem and the appropriate diagnosis codes if you would like your insurance to cover these extended visits. Our office does not accept insurance, but the proper coding will be given to you for you to be able to bill your insurance if possible. The referring professional needs to fax referral and medical information to Dr. Odineal's office, which she will review prior to your appointment (fax 530 718-3270). It is helpful for Dr Odineal to review all the history before your visit to allow ample time for testing. If you are making an appointment at In Depth Vision for this testing, you will also need to have a comprehensive evaluation of your eyes done prior to the visit. In Depth Vision Optometry is a referral practice and we want to be assured that there are not eye health problems that need to be

addressed. It is important for most neuro patients that have had traumatic brain injury or strokes to also have a threshold visual field test done as well. This test can be done at the time of the comprehensive eye examination, and also faxed to us prior to your visit. If you do not have an eye doctor to do this testing, please call our office for more information and a referral.

What can I expect on the day of my appointment?

You will need to be on time and prepared for a visit of approximately 40 minutes. Come in 20 minutes early to fill in our patient history form. If you are traveling far we will try and do as much testing as we can in one day. If you tire easily, get severe headaches, or are easily overwhelmed or confused, you may ask to break up the visit into two separate appointments. Dr. Odineal will do a thorough evaluation of eye muscle testing and teaming, balance, gait, and prescription. We will also evaluate the effect of various lenses, tints, and prisms in front of your eyes. Dr. Odineal may recommend prescription changes based on her findings, your difficulties, and your lifestyles and goals. Often recommendations are made for specific glasses and Dr. Odineal will want to reassess you after you have had time to adapt to the lenses.

What is vision therapy and what can I expect if Dr. Odineal recommends this?

Vision therapy is a prescribed series of eye/brain activities that rehabilitate visual problems such as double vision, eye teaming and tracking, perceptual problems, and difficulties resulting from visual field cuts or neglect. If you are working with an occupation/physical therapist Dr. Odineal will be communicating with them about your visual needs. Often the therapist can assist you in following simple visual activities prescribed by Dr. Odineal and her vision therapists.

Frequently patients benefit from coming to the practice every week to work with us one on one, and to be taught home visual training techniques. Often, these therapy techniques are outside the scope of practice for an OT or PT and need to be supervised by a doctor who is trained in these procedures. This is especially true for patients with double vision. Dr. Odineal's vision therapy office (In Depth Vision Optometry, 3262 Fortune Ct., Auburn, CA (530) 830-7007) has specialized equipment that will also enhance functioning of patients with visual field loss. We will provide the tools you need to do these things (lenses, prisms, stereoscopes, workbooks, etc.). You will benefit by having a partner for vision therapy to do the home activities as well coming with you to the office sessions to learn

how to do these exercises. Do not be discouraged. Change is forthcoming with perseverance. Celebrate the small changes that happen on your road to recovery.

Our vision therapy office does not accept insurance but will provide you with a superbill to have your insurance reimburse you. Medicare does not cover vision therapy and vision rehabilitation services. Remember that just because an insurance coverage does not cover a procedure or treatment does not mean that this treatment is not of great value to the patient. We have seen tremendous positive changes in our patients that choose to invest in vision therapy!

☐ I have had a medical diagnosis of brain injury (check box if true). My brain injury was: ____ years ago

☐ I suffered a brain injury without medical diagnosis (check box if true)

☐ I have NOT had a previous brain injury (check box if true)

your age _____ today's date: _____ your zip code: _____

Please check the most appropriate box, or circle the item number that best matches your observations. All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behavior occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Outdoor light too bright – have to use sunglasses	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4

Neuro-optometric Questionnaire

1. Do you experience double vision? Y N
   Is this at all times? Y N
   Is this at distance or near?

2. Do you have trouble with dizziness? Y N

3. Do you have problems with loss of place when reading? Y N

4, Do you bump into things on one side, or ignore one side? Y N

5. Do you experience eye pain, or strain? Y N

6. Do you have blur at distance or near? Y N

7. Do you have trouble with balance? Y N

8. Do letters appear to swim when reading? Y N

9. Do you feel like the room spins when turning your head? Y N

10. Do your eyes burn or feel gritty? Y N

11. Are you bothered by glare or lights? Y N

12. Tell me what is your most important visual goal:

_____

_____

_____

13. Please elaborate on any other visual problems: _____

_____

_____

_____

Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Email: _____ Last Medical Exam: _____ / _____ / _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts,

eye infections or eye injury: _____

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Arthritis	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Lupus	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Other: _____				_____

✳ *Please turn this form over and complete side two* ✳

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date