visualsense EYECARE
Optometry & Vision Therapy

ABI/TBI QUESTIONNAIRE

NAME: _____ **DATE OF LOSS: _____**

DATE: _____

Eye Injury	YES	NO
Closed Head Injury	YES	NO
Whiplash	YES	NO
Unconscious	YES	NO
CT Scan	YES	NO
MRI	YES	NO
Cranial Sacral Therapy	YES	NO
Chiropractic Therapy	YES	NO
Physiotherapy	YES	NO

Please describe any headaches you may be experiencing:

Signs / Symptoms (Eyeglasses should be worn as prescribed)

Circle the number that best represents the occurrence of each symptom.

0 – Never **1 – Sometimes** **2 – Frequently** **3 – Always**

PHYSICAL					**SINCE THE INJURY?**	
Dry, burning eyes	0	1	2	3	YES	NO
Watery eyes, itching	0	1	2	3	YES	NO
Flashes or spots in vision	0	1	2	3	YES	NO
Rubbing eyes	0	1	2	3	YES	NO
Use of eye drops	0	1	2	3	YES	NO
Eye turn	0	1	2	3	YES	NO
Eye pain	0	1	2	3	YES	NO

READING					**SINCE THE INJURY?**	
Lose place while reading	0	1	2	3	YES	NO
Skip or re-read lines	0	1	2	3	YES	NO
Fall asleep reading	0	1	2	3	YES	NO
Blur when reading	0	1	2	3	YES	NO
Double vision when reading	0	1	2	3	YES	NO
Shut one eye when reading	0	1	2	3	YES	NO
Hold closely to read	0	1	2	3	YES	NO
Poor reading comprehension	0	1	2	3	YES	NO
Dizziness/nausea while reading	0	1	2	3	YES	NO
Print moves, jumps or dazzles	0	1	2	3	YES	NO
Misalign columns or digits	0	1	2	3	YES	NO
Eye strain or headaches	0	1	2	3	YES	NO
Maximum time that you can spend reading at one time? _____ minutes						

WRITING/HAND EYE COORDINATION					SINCE THE INJURY?	
Poor handwriting	0	1	2	3	YES	NO
Difficulty pouring liquids	0	1	2	3	YES	NO
Difficulty catching a ball	0	1	2	3	YES	NO
Writes uphill or downhill	0	1	2	3	YES	NO
Reverses or omits letters	0	1	2	3	YES	NO

TV / DISTANCE VISION					SINCE THE INJURY?	
Do you drive since the MVA	0	1	2	3	YES	NO
Eye strain	0	1	2	3	YES	NO
Distance blurry	0	1	2	3	YES	NO
Double vision in distance	0	1	2	3	YES	NO
Trouble judging distance	0	1	2	3	YES	NO
Vehicles appear in wrong lane	0	1	2	3	YES	NO

LIGHTING					SINCE THE INJURY?	
Light sensitivity indoors	0	1	2	3	YES	NO
Light sensitivity in sunlight	0	1	2	3	YES	NO
Poor night vision	0	1	2	3	YES	NO
Glare of lights at night	0	1	2	3	YES	NO
Incomplete images of objects	0	1	2	3	YES	NO

WALKING					SINCE THE INJURY?	
Bumps into people or doors	0	1	2	3	YES	NO
If yes, mostly left or right		LEFT	RIGHT		YES	NO
Trips over objects or curbs	0	1	2	3	YES	NO
Ground does not appear level	0	1	2	3	YES	NO
Ground appears to move	0	1	2	3	YES	NO

STANDING/SITTING (STATIONARY)					SINCE THE INJURY?	
Feeling dizzy while still	0	1	2	3	YES	NO
Incomplete images of objects	0	1	2	3	YES	NO
Seeing objects or things that are not really there	0	1	2	3	YES	NO
Objects move while still	0	1	2	3	YES	NO
STANDING/SITTING (MOVING)					**SINCE THE INJURY?**	
Lose balance easily	0	1	2	3	YES	NO
Dizziness, nausea while moving	0	1	2	3	YES	NO

STANDING/SITTING (STATIONARY)					SINCE THE INJURY?	
Poor memory, forgetful	0	1	2	3	YES	NO
Loses belongings	0	1	2	3	YES	NO
Poor concentration	0	1	2	3	YES	NO
Easily distracted	0	1	2	3	YES	NO