Don D. Blackburn, O.D.
Talitha D'Italia, O.D.
Christy Slagle, O.D.

DELAWARE VISION ACADEMY
Developmental Optometry

Phone: 302-998-1395
Fax: 302-998-6784
3105 Limestone Road
Suite #102
Wilmington, DE 19808
Email: visionrehab@comcast.net

Head Trauma Case History

Name:_____ Today's Date:_____

Date of accident/injury: _____ Referred by:_____

Describe the accident/injury_____

_____

Type of Accident

- **Motor Vehicle** In which state did the accident happen?_____

Whiplash? YES NO **Hit head?** YES NO On what?_____

Type of vehicle_____If other vehicle(s) involved, list types_____

_____

Circle where you were sitting: Driver's seat front passenger back seat (right side)
Back seat (left side) back seat (center) unusual position

Circle which restraints were used: lap shoulder car seat booster seat air bag

Speed of your vehicle_____ Speed of other vehicle (approximately)_____

Did your vehicle hit another object? YES NO

Did the other vehicle hit your vehicle? YES NO

Circle location of impact: head on toward front driver's side
rear-ended toward rear passenger side

- **Vascular (circle)** stroke aneurysm hemorrhage other:_____
- **Toxic (circle)** medication drug abuse poison other:_____
- **Anoxic-low oxygen (circle)** drowning CO2 anesthesia other:_____
- **Other (please describe)**_____

Circle the part of the head affected by the injury: forehead right side top of head
Other: _____ face left side back of head

Were you unconscious? YES NO If so, for how long?_____

Comments: _____

_____

List of symptoms **immediately** following the accident. Check **all** that apply.

Double Vision	_____	Headache	_____	Memory Loss	_____
Blurred Vision	_____	Pain in/around eyes	_____	Vomiting	_____
Dizziness	_____	Restrictive Field of View	_____	Loss of Balance	_____
Disorientation	_____	Flashes of Light	_____	Restricted Motion	_____

Other: _____

Initial Care: Did you see a doctor concerning the accident? YES NO

Whom? _____ When?_____

Where? _____

What were you or your family told? _____

_____

Comments: _____

_____

Subsequent Care: What other professional care, for your injury/trauma, have you received or are currently receiving? Please list the names of caregivers and facilities.

Family Physician _____

Chiropractor _____

Neurologist _____

Neuropsychologist _____

Occupational Therapist _____

Physical Therapist _____

Speech Therapist _____

Audiologist/Otolaryngologist _____

Psychologist _____

Physiatrist _____

Psychiatrist _____

Optometrist _____

Ophthalmologist _____

Other _____

Additional Information necessary for Workman's compensation and Auto claims to determine the injury's impact on ocular motor and visual processing systems.

Eye exams prior to the accident? YES NO When?_____

Eye Doctor_____ Location (City/State)_____

What level of education did you complete? _____

Grades (Circle): Better than average Average Below Average

Did you require an IEP or 504 plan or accommodations for school? YES NO

Are you currently working? YES NO

Which doctor is monitoring your ability to work? _____

If you are working, do you have any work accommodations/limitations? YES NO
If yes, please list:

_____

Have you had a Defense or Insurance Medical Exam? YES NO If yes, when? _____

Is a report available? **If yes, please supply a copy.** YES NO

Billing information

Auto Claim #_____ State where accident happened? _____

Date of accident:_____ Is this your policy or the other driver's?_____

Claims adjuster name_____ Phone_____

Address_____

Workman's comp claim #_____ Date of injury_____

Claims adjuster name_____ Phone_____

Address_____

Do you have other open WC claims? YES NO

Please list your lawyers:

- Workman's comp lawyer _____ Phone_____

Lawyer's office location (City, State) _____

- Personal injury lawyer _____ Phone_____

Lawyer's office location (City, State) _____

Is this matter going to litigation? YES NO

Weighted Symptom Checklist

- After you consider each symptom, please circle the number that best describes your symptoms.

Please note whether or not symptoms were: Present before the accident **(P)**, Worsened since the accident **(W)** or new since the accident **(N)**.

Eye Teaming & Focusing Symptoms (Circle all that apply)	Never	Seldom	Occasional	Frequently	Always	**P/W/N**
Head tilt/ eye closure or cover/ face turn when reading or viewing objects	0	1	2	3	4	
Eyestrain, eye pain, trouble moving eyes, ocular fatigue, rubbing of eyes	0	1	2	3	4	
Eye drift: Left eye Right Eye Inward Outward	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Words appear to run together when reading; words move on the	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Difficulty copying from the board or taking notes	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Avoidance of or discomfort with near vision work such as reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Car and motion sickness	0	1	2	3	4	
Does not judge distances accurately (difficulty with stairs/catching a ball)	0	1	2	3	4	
Holds books too close or leans to close to computer screen	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Poor hand/eye coordination	0	1	2	3	4	
Unable to maintain eye contact or steady fixation	0	1	2	3	4	
Blurred vision: Near Distance	0	1	2	3	4	
Blurred vision is worse at the end of the day	0	1	2	3	4	
Complains of blurred vision when looking/refocusing from near to far	0	1	2	3	4	
Light sensitivity	0	1	2	3	4	

TOTAL: _____/88

Tracking Symptoms

Reading comprehension is low or declines as day wears on	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Omits small words while reading	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Substitutes words while reading or copying	0	1	2	3	4	
Head/body movements while reading	0	1	2	3	4	
Fills in the wrong bubbles on computer graded tests	0	1	2	3	4	
Loses place when reading	0	1	2	3	4	

TOTAL: _____/36

Visual Processing Symptoms

Slow word to word reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
Confuses similar words	0	1	2	3	4	
Can't recognize the same word repeated on a page	0	1	2	3	4	
Trouble with spelling and/or sight vocabulary	0	1	2	3	4	
Trouble learning left from right	0	1	2	3	4	
Reverses letters and numbers	0	1	2	3	4	
Poor spacing when writing; writes up or down hill	0	1	2	3	4	
Awkward posture or pencil grip when writing	0	1	2	3	4	
Seems to know material but does poorly on written tests	0	1	2	3	4	
Poor recall of visually presented material	0	1	2	3	4	

TOTAL: _____/44 (168pg)

Other symptoms

Decreased attention span	0	1	2	3	4	
Difficulty remembering what has been read	0	1	2	3	4	
Difficulty remembering names of people and/or objects	0	1	2	3	4	
Difficulty remembering information known in the past	0	1	2	3	4	
Difficulty remembering recognizing formerly familiar objects	0	1	2	3	4	
Difficulty remembering recognizing formerly familiar people	0	1	2	3	4	
Difficulty remembering things heard	0	1	2	3	4	
Difficulty remembering things seen	0	1	2	3	4	
Sensitivity or Nausea when objects around you move	0	1	2	3	4	
Loss of balance	0	1	2	3	4	
Tendency to drift when walking To the Right To the Left Both	0	1	2	3	4	
Disorientation	0	1	2	3	4	
Get lost often	0	1	2	3	4	
Sensitive to noise	0	1	2	3	4	
Bothered by being touched	0	1	2	3	4	
Abnormal general fatigue	0	1	2	3	4	
Restricted Field of View: Left side Right side Top Bottom	0	1	2	3	4	
Restricted Field of View: Right Eye Left Eye Both Eyes	0	1	2	3	4	
Tunnel Vision	0	1	2	3	4	

TOTAL: _____/76 (244pg)

Please list any previous head injuries.

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

Were you cleared from medical treatment following these injuries? YES NO