## **Adult Information**

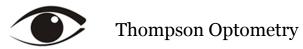
If you are a healthcare professional and would like to refer your patient for Vision Therapy to our clinic for Vision Therapy, please complete the intake form below and <a href="mailto:email

Patient Full Name:						
Patient Address:						
City:			Postal C	Code:		
Cell Phone:			Gend	er:	М	F
			Cona	<u> </u>		•
Email:						
OHIP #:			Version	Code:		
Date of Birth:	MM / DD / YYYY Date of		MVA: MM / DD / YYYY			
When was your last exam?		Who was the Eye		ye Doctor?		
Chief Complaint (Reason for your Visit)		Your Eye History:  Glaucoma Cataracts Retinal detachment Macular degeneration Colour blindness Turned or wandering eye Eye surgery Dry eye Lazy eye Vision therapy Eye injury  Do You Use:  Eye Glasses Contact lenses Sunglasses Hot compresses		Do You Currently Have:  Trouble seeing distance Trouble reading Blur Headaches Achy eyes Light sensitivity Dry eyes Red eyes Watering eyes Itchy eyes Tired eyes		
				<ul> <li>□ Burning eyes</li> <li>□ Double vision</li> <li>□ Flashes</li> <li>□ Spots</li> <li>□ Discharge from eye</li> <li>□ Nausea</li> <li>□ Dizziness</li> </ul>		



## Thompson Optometry

<ul><li>☐ Arthritis</li><li>☐ Thyroid</li><li>☐ Heart problems</li><li>☐ High blood pressure</li></ul>	☐ Eye patch☐ Magnifier	<ul><li>☐ Trouble losing belongings</li><li>☐ Poor memory/forgetful</li><li>☐ Easily distracted</li></ul>	
		Eye-Hand Coordination:  Poor handwriting Difficulty reaching for objects	
Head injury/stroke/other:	List of Medication:	Reverses/ omits letters Difficulty catching balls	
Date of loss		Driving:	
<ul><li>☐ Stroke</li><li>☐ Concussion</li><li>☐ Other</li></ul>		<ul><li>☐ Do not drive</li><li>☐ Valid driver's license</li><li>☐ License is now suspended</li></ul>	
Tests/Treatments:	List of Allergies:	<ul><li>☐ Trouble judging distances</li><li>☐ Blur Headache</li><li>☐ Eye strain</li></ul>	
☐ MRI ☐ Physiotherapy		Lighting and Glare:	
<ul><li>□ Craniosacral therapy</li><li>□ Chiropractic</li><li>□ Hospitalization</li><li>□ Other</li></ul>		<ul> <li>☐ Sensitivity in sun</li> <li>☐ Sensitivity on cloudy days</li> <li>☐ Sensitivity in office/stores</li> <li>☐ Sensitivity in home</li> <li>☐ Sensitivity at night</li> </ul>	
TV/ Distance Vision:	Lighting and Glare:	☐ Other	
<ul> <li>□ Blur</li> <li>□ Double</li> <li>□ Eye strain</li> <li>□ Too bright</li> <li>□ Squinting</li> <li>□ Trouble judging distances</li> <li>□ Other</li> </ul>	<ul> <li>☐ Sensitivity in sun</li> <li>☐ Sensitivity on cloudy days</li> <li>☐ Sensitivity in office/stores</li> <li>☐ Sensitivity in home</li> <li>☐ Sensitivity at night</li> <li>☐ Other</li> </ul>	Reading:  Lose place Skip or re-reading lines Holds book close Print swims or moves Eye strain	
☐ Do not go to school ☐ In school. Please explain any difficulties	Working/Work:  Explain why you cannot work and	<ul><li>☐ Poor comprehension</li><li>☐ Forgets what is just read</li><li>☐ Other</li></ul>	
	please explain work done before the loss and after the loss. Include when or if you expect to return to work.	Working/Work:	



	Where do you work?			
Primary Insurance Information				
Company:				
Plan Member:				
Policy:				
Member I.D:				
Secondary Insurance Information				
Company:				
Plan Member:				
Policy:				

Member I.D: