ROBERT R. JACOBS, OD
DEVELOPMENTAL OPTOMETRY & VISION THERAPY

Date: _____

Name: _____ **Date of Birth:** _____

CASE HISTORY

Please fill out as much of this form as possible. Have your family, therapist(s) and other physicians help if necessary. Bring this form to your initial evaluation appointment.

Type of current / most recent injury:

- ☐ Motor vehicle accident
- ☐ Fall
- ☐ Hit by object
- ☐ Toxic
- ☐ Anoxic
- ☐ Illness
- ☐ CVA: stroke, aneurysm, hemorrhage
- ☐ Other:

Please describe current injury:

_____

_____

_____

_____

Date of injury: _____ **Location:** _____

- ☐ I have had a medical diagnosis of brain injury
- ☐ I suffered a brain injury without medical diagnosis
- ☐ I have had an additional and/or prior brain injuries

If known, please include your diagnose(s):

_____

_____

Initial care:

- ☐ Hospital
- ☐ Urgent care
- ☐ Primary care provider
- ☐ N/A

Additional / follow-up care: **Name of provider:**

- ☐ Primary care provider _____
- ☐ Neurologist _____
- ☐ Physical therapist _____
- ☐ Chiropractor _____
- ☐ Ophthalmologist _____
- ☐ Neuropsychologist _____
- ☐ Other: _____

Reason for visit to Dr. Jacobs:

_____

_____

Referral source:

_____

Vocation or school grade/level before concussion:

_____

Describe your primary visual complaint:

Indicate any symptoms you have experienced since your injury:

General Symptoms:

_____ Blurred Vision
_____ Double Vision
_____ Field Loss
_____ Headaches
_____ Avoidance of reading
_____ Avoidance of computer
_____ Avoidance of driving
_____ Dizziness/Vertigo
_____ Nausea
_____ Balance issues
_____ Light sensitivity
_____ Sound sensitivity
_____ Sensitivity to movement of objects/people
_____ Sensitivity to movement in the periphery
_____ Difficulty locating objects in space
_____ Attention/concentration issues
_____ Memory problems

Reading symptoms:

_____ Loss of place/repeat lines
_____ Blurred vision
_____ Double vision
_____ Fatigue
_____ Poor comprehension
_____ Headaches

Any additional symptoms?