

**Auburn Family Optometry**  
**3133 Professional Drive, Suite 14**  
**(530)888-0670**

### **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. Odoneal is a board certified vision therapy/rehab doctor.

#### ***Why would I benefit from this?***

The eyes are 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. 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. Odoneal 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 the history is very important. In order for your insurance to pay for this higher level of service, ***you must have a written referral*** from a physiatrist, occupational, physical therapist or speech pathologist. The referring professional needs to fax referral and medical information to Dr. Odoneal's office, which she will review before your appointment. If you do not follow this protocol, you will need to be seen in multiple visits and may be responsible for private payment of services rendered. Generally, once our office (Auburn Family Optometry, Inc.) has received this information, we will call you to appropriately schedule the appointment. If you have not received a call from us two weeks after the recommendation from your therapist or doctor, please call us and tell our receptionist at Auburn Family Optometry that you are a patient needing a neuro-consultation and let us know who referred you.

***What can I expect on the day of appointment?***

You will need to be on time and prepared for a visit approximately one to two hours. 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. If you have recently had an eye examination, please bring or have faxed to us the previous current information from that doctor. It may allow us to do less testing—if the eye examination was after the head trauma or stroke. Dr. Odineal will do a thorough evaluation of muscle testing, balance, prescription, and eye health testing. We will also evaluate the effect of various lenses and prisms in front of your eyes. You will have a visual field (side vision evaluation) and a thorough eye health test along with dilation. Dr. Odineal may recommend prescription changes based on her findings, your difficulties, and your lifestyles and goals.

***Does my insurance cover this? What are the fees?***

Auburn Family Optometry can bill your insurance if it is not an HMO plan. Most PPO plans, including Medicare, Blue Cross and primary health insurance plans will cover this consultation and often any other necessary medical testing. Our consultation fees depend on the level of service, but are in the range of \$123-174.00. Our threshold visual field testing is \$81.00 and is billed in addition. The threshold visual field test is extremely important for the prescribing of any lenses or treatment. If you are a Medicare patient you are expected to pay 20% of the bill, as well as the refraction fee (\$39.00). Frames and lenses are generally covered by a vision insurance, and not covered by Medicare.

***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, 3240 Professional Dr. 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.). Sometimes Dr. Odineal will prescribe a computer-based therapy that can be monitored through the internet, but this therapy is not always the most appropriate for every patient. 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 it is not of great value to the patient. We have seen tremendous positive change in our patients that choose to invest in vision therapy!

- I have had a medical diagnosis of brain injury (check box if true).
- I suffered a brain injury without medical diagnosis (check box if true)
- I have NOT had a previous brain injury (check box if true)

My brain injury was: \_\_\_\_ years ago

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:*

<b>Please rate each behavior.</b> <b>How often does each behavior occur?</b> (circle a number)	Never	Seldom	Occasionally	Frequently	Always
<b>EYESIGHT CLARITY</b>					
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
<b>VISUAL COMFORT</b>					
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
<b>DOUBLING</b>					
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
<b>LIGHT SENSITIVITY</b>					
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
<b>DRY EYES</b>					
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
<b>DEPTH PERCEPTION</b>					
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
<b>PERIPHERAL VISION</b>					
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
<b>READING</b>					
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:

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13. Please elaborate on any other visual problems:

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# 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):

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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:

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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	?	NO	YES	?
<b>CONSTITUTIONAL</b>						
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>NEUROLOGICAL</b>						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>EYES</b>						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>ENDOCRINE</b>						
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>EARS, NOSE, MOUTH, THROAT</b>						
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>RESPIRATORY</b>						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>VASCULAR / CARDIOVASCULAR</b>						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>GASTROINTESTINAL</b>						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>GENITOURINARY</b>						
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>BONES / JOINTS / MUSCLES</b>						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>LYMPHATIC / HEMATOLOGIC</b>						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>ALLERGIC / IMMUNOLOGIC</b>						
<b>PSYCHIATRIC</b>						

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

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\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date