Developmental Vision Care, P.C. Kenneth R. Westcott, O.D.
601 Innovation Dr. Suite B, Chesapeake, VA 23320 **Developmental Optometrist**
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Name: _____ Date: _____

1. Date of accident / trauma: _____ 2. Referred by: _____
3. Describe the accident / trauma: _____

_____

_____

_____

Type of Accident

3A. Motor Vehicle
Type of vehicle you were in: _____
If other vehicle(s) involved, list type(s): _____

Where were you sitting? ☐ Front Seat ☐ Middle ☐ Right Side ☐ Left Side ☐ Back Seat ☐ Unusual Position

Which restraints were used? (Check all that apply) ☐ Lap ☐ Shoulder ☐ Car Seat ☐ Booster Seat

Speed of vehicle you were in: _____
Speed of other object or vehicle: _____

Did your vehicle hit another object? YES / NO
Or, did another vehicle hit your vehicle. YES / NO

If yes, where was your vehicle hit? ☐ Head On ☐ Toward Front ☐ Drivers Side ☐ Rear Ended ☐ Toward Rear ☐ Passenger Side

Did you experience whiplash? YES / NO
Did you hit your head? YES / NO
If Yes, on what? _____

3B. Other Accidents
Type (ex: home, industrial, fall, hit by object, etc.) _____
Please describe: _____

3C. Toxic
Type (ex: medication related, drug abuse, poison, etc.) _____
Please describe: _____

3D. Anoxic
Type (ex: drowning, C02, anesthesia, cord around neck, etc.) _____
Please describe: _____

3E. Vascular
Type (ex: stroke, aneurysm, hemorrhage, etc.) _____
Please describe: _____

3F. Other
Please explain: _____
Please describe: _____

4. Head Injury Description

What part of your head was affected?
☐ Forehead ☐ Back of Head ☐ Right Side ☐ Left Side ☐ Top of Head ☐ Face

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

Comments: _____
_____
_____

5. Initial Care

Did you see a doctor concerning the accident? YES / NO
Who did you see? _____
When? _____
Where? _____
What were you or your family told? _____

Comments: _____
_____
_____

6. Subsequent / Other Professional Care

What kind of professional care are you or have you received for your injuries / trauma?

Family Physician: _____
Chiropractor: _____
Neurologist: _____
Neuropsychologist: _____
Emergency Room Doctor: _____
Occupational Therapist: _____
Physical Therapist: _____
Audiologist / Otolaryngologist: _____
Psychologist: _____
Psychiatrist: _____
Optometrist: _____
Ophthalmologist: _____
Osteopath: _____
Massage Therapist: _____
Other: _____
_____

7. Symptoms immediately following the accident

☐ Double Vision
☐ Blurred Vision
☐ Dizziness
☐ Headache
☐ Pain In or Around Eyes
☐ Restrictive Field of View
☐ Loss of Memory
☐ Vomiting
☐ Loss of Balance
☐ Disorientation
☐ Flashes of Light
☐ Restricted Motion

Comments: _____
_____
_____
_____

8. Difficulties Following Accident

8A. Work Related

Please describe: _____

_____

_____

_____

8B. Hobbies / Avocational

Please describe: _____

_____

_____

_____

8C. Recreational / Social

Please describe: _____

_____

_____

_____

8D. Other

Please describe: _____

_____

_____

_____

9. Other Information

Please take the time to share with us anything else that you feel is relevant:

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. Subsequent Symptoms / Experiences

Please consider each symptom and place an “X” in all the columns that apply.
Place the “X” under MIN if the symptom is only minimally present or MAX if the symptom is very significant.

Symptom	Was present before accident		Had before accident and has worsened		New symptom since accident	
	MIN	MAX	MIN	MAX	MIN	MAX
Blurred Vision, Distance Viewing						
Blurred Vision, Near Viewing						
Slow to shift focus, near, to far, to near						
Difficulty taking notes						
Pulling or tugging sensation around eyes						
Difficulty moving or turning eyes						
Pain with movement of the eyes						
Wandering eye						
Double Vision						
Loss of place while reading						
Discomfort while reading						
Unable to sustain near work / Reading for adequate periods						
General fatigue while reading						
Eyes get tired while reading						
Headaches						
Pain in or around eyes						
Easily distracted						
Decreased attention span						
Reduced concentration ability						
Difficulty remembering what has been read						
Difficulty remembering names of objects						
Difficulty remembering people's names						
Difficulty recalling information known in the past						
Difficulty recognizing formerly familiar objects						
Difficulty recognizing formerly familiar people						
Difficulty remembering things heard						
Difficulty remembering things seen						
Dizziness						
Poor coordination						
Clumsiness						
Loss of balance						
Poor eye-hand coordination						
Poor handwriting						
Poor posture						
Head tilt						

Symptom	Was present before accident		Had before accident and has worsened		New symptom since accident	
	MIN	MAX	MIN	MAX	MIN	MAX
Face turn						
Covering, closing one eye						
Disorientation						
Get lost often						
Bothered by movement around you						
Bothered by noises around you						
Bothered by being touched						
Abnormal general fatigue						
Reduced depth perception						
Light sensitivity						
Flashes of light						
Floaters in field of view						
Restricted field of vision						
Tunnel vision						
"Curtain" billowing into field of view						