Helping athletes achieve MVP abilities

Phone: (770) 904-0979

MaxVisualPerformance.com

FORSYTH LOCATION:

2920 Ronald Reagan Blvd. #104
Cumming, GA 30041
Fax: 470-297-3854

GWINNETT LOCATION:

2055 Hamilton Creek Pkwy #120
Dacula, GA 30019
Fax: 470-655-7914

WELCOME TO MAXIMUM VISUAL PERFORMANCE
We look forward to meeting you at your appointment.

WHAT TO EXPECT AT YOUR APPOINTMENT:
Dr. Rouw and/or Dr. Shadeed will work directly with you during your evaluation which may include testing of the following visual skills: Eye Movement Control, Simultaneous Focus at Far, Sustaining Focus at Far, Simultaneous Focus at Near, Sustaining Focus at Near, Simultaneous Alignment at Far, Sustaining Alignment at Far, Simultaneous Alignment at Near, Sustaining Alignment at Near, Central Vision (Visual Acuity), Prescription for glasses, Peripheral Vision, Depth Awareness, Color Perception, Gross Visual-Motor, Fine Visual-Motor, Visual Perception, and Visual Integration.

FEES and PAYMENTS: Maximum Visual Performance is not a provider for insurance plans and does not submit claims to insurances. **ALL FEES FOR YOUR APPOINTMENT ARE DUE AT THE TIME OF THE SERVICE AND IS THE RESPONSIBILITY OF THE PATIENT/PARENT(S)/GUARDIAN(S).**

CANCELLED OR MISSED APPOINTMENTS: Please understand that each appointment time is dedicated to you and is therefore not available to anyone else. We understand emergencies occur, please notify us as soon as possible if you are unable to keep your appointment. If you have not cancelled your appointment and do not show, you are making this appointment time unavailable for others**.**

There is a $35.00 Fee for Not Showing for your appointment and/or Cancellations within 24 hours.

I understand that if I cancel or no-show for 2 consecutive appointments, I will be subject to removal from the schedule including all future appointments at the discretion of MVP.

Signature_____ Date_____

MVP Post-Concussion Assessment Medical History Form

Name_____ Date _____ Date of Birth_____/_____/_____
Month Day Year

Mailing address_____
Street City State Zip Code

Contact Number: Hm_____Cell _____ Email:_____

EYECARE DOCTOR:_____ Date of Exam_____/_____/____
Name of Eyecare doctor Month Day Year

Location of Eye Exam _____
Name of Practice /Address Phone

MEDICAL DOCTOR:_____ Date of Exam_____/_____/_____
Name of Medical doctor Month Day Year

Location of Medical Exam_____
Name of Practice /Address Phone

How did you hear about us? □Friend □Internet □Optometrist □Rehabilitation therapist □Physician □Other_____

REFERRAL INFORMATION: The results of the testing will be sent to the referring professional.

You are referred by _____ Reason for Referral _____

Address_____Phone Number_____

INFORMATION RELEASE: If you would like information sent to any addition person, please provide the following:

_____
Name Address City/ State Zip Phone Fax

Profession Type □ Primary Care Physician □ Rehabilitation therapist □ Optometrist □ Other _____

_____
Name Address City/ State Zip Phone Fax

Profession Type □ Primary Care Physician □ Rehabilitation therapist □ Optometrist □ Other _____

GENERAL HEALTH MEDICAL HISTORY

List ALL Allergies to Medications and/or Foods _____

List ALL Medications currently taking _____

List ALL major surgeries and/or hospitalization _____

_____

_____

List ALL previous eye injuries _____

_____

CONCUSSION HISTORY

Date of Concussion _____ Is this your first head injury □ Yes □ No. If No please list date of previous injury(s):

_____

_____

Sports/Activity at time of Concussion _____ Location of impact _____

Symptoms noted at time of injury: □loss of vision □double vision □loss of consciousness □dizziness □vomiting □other (please explain) _____

FAMILY HISTORY Have any of your (the patient's) relative- living or decease had any of these conditions?

Ocular Disease/ Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Blindness	☐	☐	☐	_____
Eye Turn (Strabismus)	☐	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Other _____				_____

Systemic Disease/ Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Arthritis	☐	☐	☐	_____
Cancer / Type _____	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Other _____				_____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV/AIDS ☐ Syphilis ☐ Other_____ ☐ None

PATIENT'S REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

System	**Yes**	**No**	**Not Sure**		**System**	**Yes**	**No**	**Not Sure**
Skin (Integumentary)					**Psychiatric**			
Psoriasis					ADHD/ ADD			
Other:					Dyslexia			
Neurological					Anxiety			
Headache / Migraine					Other:			
Seizures					**Ears, Nose, Mouth, Throat**			
Autism Spectrum / Asperger					Seasonal Allergies/ Hay fever			
Sensory Disorder					Sinus Congestion			
Cerebral Palsy					Runny Nose			
Vomiting					Chronic Cough			
Clumsiness					Dry Throat/ Mouth			
Eyes					**Respiratory**			
Loss of Vision					Asthma			
Blurred Vision					Chronic Bronchitis			
Distorted Vision / Halos					Emphysema			
Double Vision					**Vascular / Cardiovascular**			
Dryness / Sandy Gritty Feeling					Diabetes			
Mucus Discharge					Heart Pain			
Redness					High Blood Pressure			
Itching / Burning					Vascular Disease			
Excess Tearing / Watering					Brain Injury / Stroke			
Tired Eyes					Other:			
Eye Pain/ Soreness					**Gastrointestinal**			
Sties / Chalazion					Diarrhea and/or constipation			
Flashes / Floaters in Vision					**Bones/ Joint/ Muscles**			
Endocrine					Arthritis			
Thyroid / Other Glands					Muscle and/or Joint Pain			
Allergic/ Immunologic					Lymphatic/ Hematological			
Fever, Weight Loss/ Gain					Anemia/Bleeding Problems			
Other:					Other:			

NAME:_____DOB: _____ DATE:_____

VISUAL QUESTIONNAIRE

Instructions: Pose the following questions exactly as written. If the patient responds with "yes" - please qualify with frequency choices. Do not give examples.
Patient instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

		Frequency				
	Possible Subjective Symptoms	**Never (0)**	**Infrequently/ Not very often (1)**	**Sometimes (2)**	**Fairly Often (3)**	**Always (4)**
1.	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have trouble remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read slowly?					
10.	Do your eyes ever hurt when reading or doing close work?					
11.	Do your eyes ever feel sore when reading or doing close work?					
12.	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13.	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14.	Do you lose your place while reading or doing close work?					
	Total score					
15.	Do you notice one eye that turns In / Out / Up / Down (circle one)					
16.	Blurry vision in the distance after prolonged close work?					
17.	Closes one eye when reading or doing close work?					
18.	Omits words when reading?					
19.	Fills in the wrong bubbles on a computer graded test?					
20.	Misaligns or misplaces numbers in columns?					
21.	Poor handwriting, or writes uphill or down hill?					
22.	Difficulty copying from the board at school?					
23.	Writes letters and/or numbers backwards?					
24.	Inconsistent performance in school?					
25.	Inconsistent or poor at sports?					
26.	Persistent difficulty learning to spell?					
	Total score					

1. What are your/ parent's/ guardian's goals in neuro-vision rehabilitation?

_____

_____

_____

2. Are there any considerations in your participating in neuro-vision rehabilitation for us to be aware? ☐Yes ☐No
If yes, please explain (e.g., time availability, behavioral or physical limitations, etc) _____

_____

_____

MVP SPORTS VISION TRAINING

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MEDICAL RELEASE

I hereby understand and authorize Maximum Visual Performance obtain and/or exchange written and verbal information for the purpose of medical, visual, psychological, and/or educational evaluation. As vision therapy services at the Maximum Visual Performance can be a part of a multidisciplinary team, this authorization may include, but not limited to the following: Patient's eye care professional, referral professional, occupational therapist, physical therapist, speech therapist, behavioral therapist, school counselors/administrative, and pediatricians/medical physicians. The Maximum Visual Performance communicates with the patient/parent/guardian/ and the multidisciplinary team via: Fax, Email, Text, Postal mail, and/or Verbal communication. **Documents including but not limited to the following: initial evaluation reports, progress reports, letters of medical necessity, prescriptions, classroom accommodations may be emailed. _____ Initials**

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that my medical records include information regarding drug abuse/alcoholism/alcohol abuse/psychological/psychiatric conditions/ medical history including exposures or infections to diseases/ visual history and authorize the release of this information.

I do hereby release Maximum Visual Performance and its directors, agents, doctors, employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.

Patient/Parent/Guardian Signature_____ Date_____

Relationship to Patient_____ Print Name_____

HIPAA AGREEMENT

I acknowledge that I understand the Notice of Privacy Practices provided by the MVP and a copy has been shown/ provided to me upon request.

Patient/Parent/Guardian Signature_____ Date_____

Relationship to Patient_____ Print Name_____