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Vision Therapy • Neuro-Optometry • Low Vision Rehab
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Low Vision Rehabilitation Intake Form

Patient Name:_____ **Today's Date:**_____

VISION HISTORY

What are your current vision concerns?

What kind of glasses have you been wearing (bifocal, trifocal, progressive, distance only, near only, etc.), and how old is the prescription?

When was your last eye exam and/or ophthalmologist exam?

Who is your eye doctor and the clinic name? List multiple doctor/clinics if necessary.

Do you want us to send reports to any of the doctors listed above? If so, please circle them.

LOW VISION HISTORY

Have you had previous low vision care by a low vision specialist (not a retina specialist or surgeon)? If so, please tell us the doctor/clinic name.

Are you currently using any low vision devices? If so, please list them.

Do you currently drive? Yes No

What is your current living situation?

What are your goals for low visions rehabilitation?