Patient Name (F) _____(MI)_____(L)_____Preferred Name_____

Address_____City_____State/Zip _____

Social Security Number_____ Date of Birth_____ Male ☐ Female ☐

Email address_____ Home Phone (___)_____Cell(___)_____

Employer_____ Occupation _____

Work Phone (___) _____ Ext._____

Person Responsible for Account_____Address_____

Emergency Contact and Phone number_____

Referring Therapist, Doctor, or Dentist_____City/State_____

How did you hear about us? Physical Therapist Optometrist Another Doctor Friend Relative

Internet/Website Other_____

Primary Eye Doctor_____City/State_____Phone_____

Primary Physician_____City/State_____Phone_____

My main reason for being seen is:_____ This began:_____

What is it you want to do that you can't do now?_____

Previous Surgery(s) or Significant Trauma:_____

_____

Do you have, or have had, any of the following:

GENERAL HEALTH:

Diabetes	YES	NO
Weight Loss	YES	NO
Allergies	YES	NO
Type _____		
Are you allergic to Latex? _____		
Digestive Disease	YES	NO
Metal Implants	YES	NO
Heart Problem	YES	NO
Depression	YES	NO
Seizures	YES	NO
Pregnant (Currently)	YES	NO

NECK/JAW/HEAD:

Do you experience facial pain?	YES	NO
Do you feel a click or pop when you open or close your mouth?	YES	NO
Migraines/Headaches	YES	NO
Do you feel pain in the front of your ear, or ear "fullness" or "ringing"?	YES	NO
Do you feel tension in your neck or at the base of your skull?	YES	NO
Head Trauma/Whiplash	YES	NO
Concussion	YES	NO

LUMBO/PELVIC/FEMORAL:

Do you ever experience small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise?	YES	NO
Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing?	YES	NO
Do you experience hip or groin pain?	YES	NO
Do you experience low back pain?	YES	NO

BREATHING:

Do you still feel tired after a full night of sleep?	YES	NO
Do you have asthma?	YES	NO
Do you have to sleep in an upright position?	YES	NO
Have you been diagnosed with sleep apnea?	YES	NO

FEET:

Do you have flat feet?	YES	NO
Do you have pain on the bottom of your feet when you are standing?	YES	NO
Do you use orthotics, heel lifts, or any other foot inserts in your shoes?	YES	NO
Does one of your feet turn out more than the other?	YES	NO
Do you feel unstable on one or both of your feet or legs?	YES	NO

VISION:

Lazy Eye	YES	NO
Eye Turn	YES	NO
Double Vision	YES	NO
Intermittent Blurred Vision	YES	NO
Lose place while reading	YES	NO
Eyestrain	YES	NO
Light Sensitive	YES	NO
Retinal Detachment	YES	NO
Macular Degeneration	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Eye Surgery	YES	NO
Difficulty at the computer	YES	NO

Number of hours/day on a computer: for work_____

for pleasure_____

When was your last eye examination? _____

Do you wear glasses now? NO YES When? _____

Do you wear contact lenses at this time? NO YES When? _____

What type? _____

Are you Left or Right Handed? _____

Are there any activities you do with your non-dominant hand?

_____

_____

Please list all medications you are currently taking and for what condition:

_____ _____

_____ _____

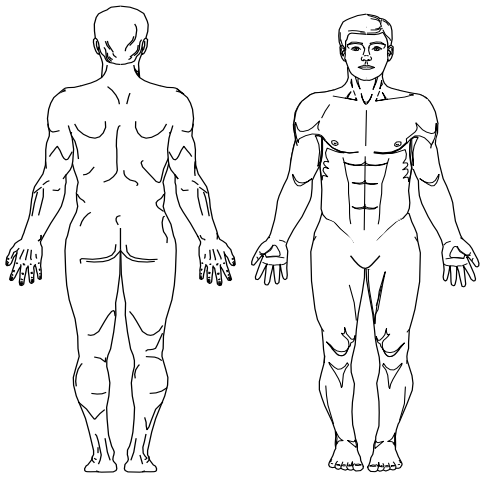
_____ _____

_____ _____

PLEASE INDICATE ON THE PICTURES TO THE RIGHT THE **LOCATION OF YOUR ISSUE(S)**
&
PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST** AND **BEST** ON THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10

0 = NO DISCOMFORT **10 = EXTREME DISCOMFORT**



MEDICALLY INFORMED CONSENT AND ASSIGNMENT AND RELEASE

I voluntarily consent to PRI Vision treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of integrating physical therapy and optometry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at PRI Vision LLC. It is PRI Vision's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's/optometrist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed **one year**.

I hereby understand that I am financially responsible for these non-covered services. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at PRI Vision LLC.**

I (or_____ for _____) have read this form and fully understand and accept its terms and conditions.

_____

Patient or person authorized to consent for patient / relationship Date / Time

_____

Reason patient was unable to consent Witness signature

Acknowledgement of Receipt of Notice, PRIVACY PRACTICES
PRI VISION LLC

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate Relationship:
- □ parent or guardian of minor patient
- □ guardian or conservator of an incompetent patient
- □ beneficiary or personal representative of deceased patient

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
Our office's complete NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations & other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.