

## **INSTRUCTIONS FOR FILLING OUT SELF ASSESSMENT FORM**

1. Referring discipline/person needs to fill out **BOTH** pages of the Self Assessment Form.
2. Fax completed form to Kelly at (402) 467-4580.
3. Ron and Dr. Heidi Wise will review the information. They will determine if the patient is appropriate for PRI Vision and the amount of time needed to evaluate the patient.
4. Kelly will contact the patient to schedule the evaluation once Ron and Dr. Heidi Wise have reviewed and approved the patient to be seen by PRI Vision.

PRI Vision, LLC  
5241 R St., Suite 3  
Lincoln, NE 68504  
Phone: (402) 467-4545  
Fax: (402) 467-4580

## Self Assessment Form For PRI Vision Clinic

Name: \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Source (self, physician, dentist, etc.): \_\_\_\_\_

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1. Please fax your last three eye exam records (the complete exam records including eye health, not just the refraction) to us. Your most recent eye exam must be within the last 18 months.
2. Chief complaints and reasoning behind your need to come to PRI Vision Clinic.  
Examples: Headaches, dizziness, vertigo, back pain, etc.

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3. Medical History: Have you suffered from any of the following:

- |  |   |   |
|--|---|---|
| a. Head/Brain injury?                      | Y | N |
| b. Whiplash injuries?                      | Y | N |
| c. Concussions (diagnosed or undiagnosed)? | Y | N |
| d. Lost consciousness?                     | Y | N |

If yes to any of the above, please briefly describe what kind of injury and when.

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4. Dental – TMJ History

- |  |   |   |
|--|---|---|
| a. Are you presently wearing a mouthpiece?                   | Y | N |
| b. Do you have OR have you had braces?                       | Y | N |
| c. Do you have clicking, popping or jaw opening limitations? | Y | N |
| d. Do you clench or grind?                                   | Y | N |
| e. Do you have jaw or facial pain?                           | Y | N |

5. Please summarize issues that you possibly have had with your eyes. Example: Pain behind eyes, lasik surgery, blurry vision, etc.

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6. Without rotating or moving your body, can you turn your head to each direction? Y N  
Do you feel limitations to either direction? Y N  
If yes, which direction? \_\_\_\_\_

7. How many hours per day are you in front of a computer? \_\_\_\_\_

8. Please circle what you put over or on your eyes (please circle all that apply):

- a. Nothing
- b. Contacts
- c. Glasses
- d. Sunglasses
- e. Bifocals:        Lined                No line/Progressive

9. Are you seeing a physical therapist?    Y    N  
If yes, who? \_\_\_\_\_

10. Is there anything else significant about your physical or health history we need to be aware of?

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