learning · sport · rehab
VISION BEYOND 20/20

Full Name: _____ **Preferred Name:** _____

DOB: _____ (MM/DD/YYYY) **Gender : M / F**

Address: _____ **City:** _____ **State/Zip:** _____

Home Ph: ( )_____ **Wk Ph: ( )**_____ **Other/Cell ( )**_____

Email: _____

Emergency Contact: _____ _____ _____
(Name) *(Phone Number)* *(Relationship to Patient)*

Guardian(s)/Guarantor(s): _____ _____ **Same Address? Y N**
(Party responsible for billing) *(Relationship to Patient)* *(If not, please write in space below)*

_____

School Name: _____

Whom can we thank for referring you to our office? _____

Phone: _____ **Address:**_____

VISUAL HISTORY

For what reason(s) are you bringing your child to our office today?

_____

Has your child's vision been previously evaluated? Yes ☒ No ☒

Date of last Vision Exam: _____ Doctor: _____ Date of last dilation: _____

Were glasses, contact lenses, or other optical devices prescribed? **Y N** If YES, which? _____

Do you use them? **Y N** If yes, when? _____ If no, why not? _____

If you wear contact lenses, how long have you worn them? _____

What type of lenses do you have (ie. hard, soft, gas-permeable)? _____

What solutions do you use?

_____

PRESENT CONDITION(S)

Does the patient currently suffer from (please check all that apply):

- ❑ Blurred vision at distance or near
- ❑ Red, burning, itchy or watery eyes
- ❑ Headaches
- ❑ Loss of place or skips lines when reading
- ❑ Motion / car sickness
- ❑ Double vision at distance or near
- ❑ Difficulty sustaining reading / writing
- ❑ Repeats or omits words when reading

List any other complaints your child makes concerning his/her vision:

_____

_____

MEDICAL HISTORY

Physician's Name: _____ Date of most recent visit: _____

Reason for visit: _____

Current Medications (including vitamins and supplements):

_____

_____

Is patient allergic to any medications? _____

REVIEW OF SYSTEMS (*Please mark the appropriate response below)*

Constitutional *None*_____
- ❑ headaches
- ❑ weight loss
- ❑ fever
- ❑ fatigue
- ❑ trauma
- ❑ migraines
- ❑ cancer _____

Skin/Integumentary *None*_____
- ❑ eczema/psoriasis
- ❑ skin cancer
- ❑ acne

Cardiovascular *None*_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ stroke
- ❑ high cholesterol

Respiratory *None*_____
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema

Neurological *None*_____
- ❑ multiple sclerosis
- ❑ epilepsy

Gastrointestinal *None*_____
- ❑ ulcer
- ❑ food allergy
- ❑ digestive disorder

Genitourinary *None*_____
- ❑ urinary tract infections
- ❑ STD

Musculoskeletal *None*_____
- ❑ fibromyalgia
- ❑ arthritis
- ❑ muscular dystrophy

Ears, Nose, Throat *None*_____
- ❑ hearing problems
- ❑ upper respiratory tract infection

Psychiatric *None*_____
- ❑ depression
- ❑ panic disorder
- ❑ ADD / ADHD

Endocrine *None*_____
- ❑ diabetes
- ❑ thyroid problems
- ❑ hormonal problems

Hematologic/Lymphatic *None*_____
- ❑ anemia
- ❑ leukemia
- ❑ clotting disorder

Allergic/Immunologic *None*_____
- ❑ seasonal allergies
- ❑ lupus

Eyes *None*_____
- ❑ amblyopia / lazy eye
- ❑ strabismus/ crossed eye
- ❑ glaucoma
- ❑ eye surgery _____
- ❑ cataract

FAMILY HISTORY

Is there any history of the following? *(please check all that apply)*

YES	*Relationship to Patient?*	YES	*Relationship to Patient?*
❑ Diabetes	_____	❑ Amblyopia	_____
❑ High Blood Pressure	_____	❑ Strabismus	_____
❑ Epilepsy or Seizures	_____	❑ Glaucoma	_____
❑ Thyroid	_____	❑ Macular Degeneration	_____

If other, please explain:

_____

Immunizations

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Any reactions to immunization(s)? Yes ☒ No ☒ If yes,, please explain: _____

_____

List illnesses, bad falls, high fevers, other accidents such as auto, bicycle, etc.

Age	Severe	Mild	Complications

Is your child generally healthy? Yes ☒ No ☒

If no, explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: _____

Has a neurological evaluation been performed? Yes ☒ No ☒

By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☒ No ☒

By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☒ No ☒

By whom? _____ Results and recommendations: _____

Is there any history of the following? (please check if there is a history)

	Patient	**Family**	**Relationship to Patient**
Chromosomal Imbalance	☒	☒	_____
Learning Disability	☒	☒	_____
Epilepsy or Seizures	☒	☒	_____
Multiple Sclerosis	☒	☒	_____
"Crossed" or "Wall" eye	☒	☒	_____

If other, please explain: _____

_____

NUTRITIONAL INFORMATION

How would you classify your current Diet: Excellent ☒ Good ☒ Fair ☒ Poor ☒

Does your child: Like sweets ☒ or crave sweets ☒

If yes, what types? _____

Is your child physically active? Yes ☒ No ☒ Moderately? ☒ Extremely? ☒

Are there periods of:

Very high energy? Yes ☒ No ☒

Very low energy? Yes ☒ No ☒

Please explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐

Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, please explain: _____

Normal delivery? Yes ☐ No ☐

Any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain:

_____

Birth weight: _____ APGAR scores @ birth: _____ After 10 minutes: _____

Were forceps used? Yes ☐ No ☐

Was there ever any reason for concern over your child's general growth or development? Yes ☐ No ☐

If yes, why? _____

_____

Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____

Did your child creep (on all fours)? Yes ☐ No ☐ At what age? _____

If not, describe: _____

_____

At what age did your child walk? _____

At what age did your child first speak: _____ First words: _____

Was early speech clear to others? Yes ☐ No ☐

Is speech clear now? Yes ☐ No ☐

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

Please check all that apply. Some may not apply because of the age/development of your child.

	Yes	No	If yes, how often?
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent sties	☐	☐	_____
Frowning	☐	☐	_____
Bothered by light	☐	☐	_____
Frequent blinking	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Head close to paper when reading or writing	☐	☐	_____
Avoids reading	☐	☐	_____
Prefers being read to	☐	☐	_____
Tilts head when reading	☐	☐	_____
Tilts head when writing	☐	☐	_____
Moves head when reading	☐	☐	_____

Confuses letter or words	☐	☐	_____
Reverses letter or words	☐	☐	_____
Confuses right and left	☐	☐	_____
Skips, rereads or omits words	☐	☐	_____
	Yes	No	If yes, how often?
Loses place while reading	☐	☐	_____
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Writes neatly but slowly	☐	☐	_____
Does not support paper when writing	☐	☐	_____
Awkward or immature pencil grip	☐	☐	_____
Frequent erasures	☐	☐	_____
Tires easily	☐	☐	_____
Difficulty copying from chalkboard	☐	☐	_____
Difficulty recognizing same word on diff page	☐	☐	_____
Poor word attack skills	☐	☐	_____
Difficulty with memory	☐	☐	_____
Remembers better what hears than sees	☐	☐	_____
Responds better orally than by writing	☐	☐	_____
Seems to know material, does poorly on tests	☐	☐	_____
Dislikes / avoids near tasks	☐	☐	_____
Short attention span / loses interest	☐	☐	_____
Poor large motor coordination	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty with scissors / small hand tools	☐	☐	_____
Dislikes / avoids sports	☐	☐	_____
Difficulty catching or hitting a ball	☐	☐	_____

SCHOOL

Age at time of entrance to: Pre-school_____ Kindergarten_____ First Grade_____

Does your child like school? Yes ☐ No ☐

Specifically describe any school difficulties: _____

_____

Has your child changed schools recently? Yes ☐ No ☐

If yes, when? _____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? _____

Does your child seem to be under tension or extreme pressure when doing school work? Yes ☒ No ☒

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☒ No ☒

If yes, when? _____

Where and from whom? _____

How long? _____

Results: _____

_____

Does your child like to read, voluntarily? Yes ☒ No ☒

Does your child read for pleasure? Yes ☒ No ☒

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____

_____

How would you rate your child's overall schoolwork: Above average ☒ Average ☒ Below Average ☒

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes ☒ No ☒

How much time on average does your child spend each day on homework assignments? _____

To what extent do you assist your child with homework? _____

Do you feel your child is achieving up to their potential? Yes ☒ No ☒

Does the teacher feel your child is achieving up to their potential? Yes ☒ No ☒

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☒ No ☒

If yes, what? _____

Are there any behavior problems at home? Yes ☒ No ☒

If yes, what? _____

What causes these problems? _____

Child's reaction to fatigue? Sad ☒ Irritable ☒ other _____

Child's reaction to tension? Avoidance ☒ Irritable ☒ other _____

Does your child say and/or do things impulsively? Yes ☒ No ☒

Is your child in constant motion? Yes ☒ No ☒

Can your child sit still for long periods? Yes ☒ No ☒

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother ☒ Father ☒ Stepmother ☒ Stepfather ☒

Foster Parents ☒ Adoptive Parents ☒ Grandmother ☒ Grandfather ☒ Aunt ☒ Uncle ☒

Other Caretaker (please specify): _____

Does your child spend time with any other person, not in the home? Yes ☒ No ☒

Please explain: _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)?
Yes ☒ No ☒ If yes, at what age: _____

Does your child seem to have adjusted? Yes ☒ No ☒

Was counseling /therapy undertaken? Yes ☒ No ☒

If yes, is it on-going? Yes ☒ No ☒

Is family life stable at this time? Yes ☒ No ☒

if no, please explain: _____

How does your child get along with:

Parents/other caretakers? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes ☒ No ☒ If yes, who? _____

Did mother or anyone in mother's family have a learning problem? Yes ☒ No ☒ If yes, who? _____

To what extent? _____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? Yes ☒ No ☒ If yes, how much/often? _____ Viewing distance? _____

Does your child spend time using computer/video games? Yes ☒ No ☒ If yes, how much/often? _____
Viewing distance? _____

What other activities occupy your child's leisure time? _____

Are there any activities your child would like to participate in, but doesn't/can't? _____

Please explain: _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

_____

_____

_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD? _____

IMPORTANT INFORMATION REGARDING HIPAA PRIVACY:

_____ *(initials)* I acknowledge that I have read a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information, in part, can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the health-care providers who may be involved in that treatment directly and indirectly*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

RELEASE OF INFORMATION

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Vision NOW when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment or the treatment of my child or ward.

Signature of Patient or Authorized Representative _____ **Date** _____

(For office use only:)

Reviewed by _____ *Date* _____ || *Reviewed by* _____ *Date* _____ *Changes* _____ || *Reviewed by* _____ *Date* _____ *Changes* _____