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CHILDREN'S QUESTIONNAIRE

Child's Name: _____ Nickname:_____
Address: _____
Town: _____ State: _____ Zip Code: _____
Home telephone: _____ Date of Birth: _____ Grade: _____
School: _____ Teacher's Name: _____
Referred by: _____

Father's Name: _____ Occupation: _____
Date of Birth: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____

Mother's Name: _____ Occupation: _____
Date of Birth: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____

Parents, may we add you on Facebook?___ If yes, what is your contact name?_____

Brothers and Sisters	Birthdate	Age	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENT SITUATION

1. In what ways does your child seem to have visual and/or school difficulties?

_____
_____
_____

2. How long has the difficulty been noted? _____

3. What kind of complaints does your child make about his/her vision? _____

_____

_____

4. Does your child report any of the following and, if so, when?

	Yes	No	When
• Headaches	___	___	_____
• Blurred vision	___	___	_____
• Double vision	___	___	_____
• Eyes hurt or tired	___	___	_____
• Car sickness	___	___	_____

5. Have you or anyone else noted the following:

	Yes	No	When
• Holding reading material close	___	___	_____
• Closing or covering an eye when reading	___	___	_____
• Eyes frequently red	___	___	_____
• Excessive eye rubbing	___	___	_____
• Excessive blinking	___	___	_____
• Getting "lost in the book"	___	___	_____
• Tilting head when reading	___	___	_____
• Inability to see distant objects clearly	___	___	_____
• Bumping into objects	___	___	_____
• Poor general coordination	___	___	_____
• Bothered by light	___	___	_____
• Extreme fatigue	___	___	_____
• Uses finger when reading	___	___	_____
• Reverses or skips words	___	___	_____

SCHOOL

1. Age at time of entrance to nursery school: _____ Kindergarten: _____ 1st Grade: _____

2. Does your child like school? _____ If no, why not? _____

_____

3. Has a grade been repeated? _____ If so, which grade(s): _____

4. Have there been any school difficulties? _____ If so, please explain: _____

_____

5. Is school work: average _____ better than average _____ or below average _____

6. Is there any subject which seems particularly easy for your child? _____

_____

7. Is there any subject which seems particularly difficult for your child? _____

_____

8. Has any special testing or remedial work been done? _____ If so, by whom and when? _____

_____

9. Has there been any specific diagnosis made? _____

_____

DEVELOPMENTAL HISTORY

1. Term of pregnancy _____ Normal birth ____ or were there any complications before, during or immediately following delivery? _____

_____

2. Did your child crawl? _____ on all fours? _____ at what age? _____

3. At what age did your child sit alone? _____ walk alone? _____

4. Speech: Age when first word spoken _____ sentences _____ was speech clear to others? _____

5. Was your child active as a baby? _____

6. When fatigued, which does your child do? sags ____ becomes irritable ____ becomes excited ____

7. When under stress, is there any pattern of behavior such as thumb sucking, nail biting, etc.? _____

_____

GENERAL HEALTH

1. Please list past illnesses including any history of high fever or significant injuries and the age at which they occurred? _____

_____

2. Health at the present time is: good _____ fair _____ poor _____

3. Is your child under any medication? _____ If so, what? _____

_____

4. Name and address of pediatrician: _____

_____

5. Is there any family history of diabetes, high blood pressure or other serious health condition? _____

_____

VISUAL HISTORY

1. Have your child's eyes ever been crossed or turned out? _____ If yes, when? _____

2. Have you ever been told that your child has a "lazy" eye? _____

3. Please list previous vision/eye exams, including doctor's name, date seen, reason for exam, and the results of that exam (use the back of this page if needed):

- _____
- _____
- _____

4. Are there other members of the family who have had vision or eye problems? _____ If yes, what kind of problem(s)? _____

5. Please give a brief description of your child's personality: _____

_____

6. Is there anything else you want us to know that you don't want to say in front of your child? _____

If yes, what? _____

CONTACT LENS HISTORY

Do you wear contact lenses? ____ Soft or RGP? _____ If not, are you interested? _____

When did you start wearing contact lenses? _____

Type and brand of contact lenses: _____

How many hours per day: _____ How many days per week: _____

We would like to share our findings with other professionals who participate in the care and education of your child. Please check any of the following to whom you would like us to send a report.

(Please include full name and address)

_____ Pediatrician _____

_____ Teacher _____

_____ Tutor _____

_____ School counselor _____

_____ School nurse _____

_____ Learning or reading center _____

_____ Speech therapist _____

_____ Reading specialist _____

_____ Occupational therapist _____

_____ Physical therapist _____

_____ Special education teacher _____

_____ Other _____

_____ Other _____

Parent's or guardian's signature _____ Date _____

Your signature acknowledges receipt of our Notice of Privacy Practice and also authorizes us to file insurance claims on your behalf.

FINANCIAL RESPONSIBILITY STATEMENT

To Our Patients with Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your insurance benefit as designated by the _____ Plan of which you state you are a member. This service will be provided without additional charge to you. We will also do all that we can to help you receive maximum benefits.

However, in the event that the insurance plan determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all charges incurred by you, and not paid by your insurance plan.

RESPONSIBLE PARTY: _____

_____

Signature Date

BILLING ADDRESS: _____

Street Address/Apt. #

_____

City, State, Zip

_____

Telephone

CANCELATION POLICY

All patients will be charged $55.00 for missed appointments if 48 hours notice is not given for cancellation.
I have read this statement and agree to the above.

Patient's or parent's signature _____ Date _____

CELL PHONE POLICY

PLEASE PUT YOUR CELL PHONE ON SILENT MODE
During evaluations and vision therapy sessions, it is important that you are not distracted or your child during the appointment. During a child's evaluation, it is also important that you observe the testing and how your child responds. If for some reason there is a call you have to take, please step out of the room to do that.

Please initial _____ Date _____