

Alderwood

Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a vision examination for your child. On the following pages you will find a “Children’s Vision Questionnaire”. Please either return the completed form to our office before your scheduled appointment, or bring it with you to the appointment.

Parents/guardians are always welcome to stay with their child for the entire appointment, but space is limited for siblings. If arrangements can be made for childcare it would be helpful because additional noise is very distracting.

Thank you again for your cooperation in providing this complete history for your child.
We look forward to seeing you!

16006 Ash Way, Suite 101, Lynnwood, WA 98087
Phone: (425) 787-5200 Fax: (425) 787-5252

Nancy G. Torgerson
Doctor of Optometry

DRIVING DIRECTIONS

**Alderwood Vision Therapy Center, PLLC
16006 Ash Way, Suite #101
Lynnwood, WA 98087
(425) 787-5200**

Southbound on I-5 coming from Everett, WA

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-5 coming from Seattle, WA

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-405

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

From the Edmonds Ferry:

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

Our office is located in a separate building at the north end of Newberry Square.

CHILDREN'S STRABISMUS QUESTIONNAIRE

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____
Patient's Nickname: _____

GENERAL INFORMATION

Were you referred to our office? Yes No
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____ Profession: _____
Child's Full Legal Name: _____ Male _____ Female _____
Birth Date: _____ Age: _____ years _____ months
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Name and address of school: _____
Grade: _____ Teacher: _____
Child's dominant hand (circle): right / left / undetermined?

Please list the names and birth dates of your family:

Father/Caretaker	_____	Birth Date	_____
Mother/Caretaker	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____

ACCOUNT RESPONSIBLE INFORMATION

Person Responsible for Account: _____ Relationship to Patient: _____
Account Responsible Address: _____
Account Responsible SSN: _____ Home Phone: _____
Father/Caretaker's Occupation: _____ Work Phone: _____
E-mail: _____ Cell Phone: _____
Mother/Caretaker's Occupation: _____ Work Phone: _____
E-mail: _____ Cell Phone: _____
In Case of Emergency Contact: _____ Phone: _____

Do you have Vision Insurance? Yes No If so, who is the carrier? _____
Insurance Address: _____ Insurance Phone: _____
Subscriber Name: _____ DOB: _____ SSN: _____
Subscriber ID# (incl. letter prefix): _____ Group #: _____

Do you have Medical Insurance? Yes No If so, who is the carrier? _____
Insurance Address: _____ Insurance Phone: _____
Subscriber Name: _____ DOB: _____ SSN: _____
Subscriber ID# (incl. letter prefix): _____ Group #: _____

PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S) WITH YOU TO YOUR APPOINTMENT.

MEDICAL HISTORY

Pediatrician's Name: _____

Child's current state of health: _____

Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

Any allergies to medications? _____

List illnesses, bad falls, high fevers, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>

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 your child been diagnosed on the autism spectrum? Yes No

Does your child have a seizure disorder? Yes No

Does your child have a sleep disorder? Yes No

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 / speech / physical therapy evaluation been performed? Yes No

By whom? _____ Results and recommendations: _____

Has your child or a family member been treated for any condition related to:

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematological/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
"Cross"/"Wall" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other, please explain: _____

Date: _____ Dr's Initials: _____

Any history in your family of an eye turn resulting from a disease or other condition? Yes No

Other health problems? Yes No

If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?

Yes No

If yes, please explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Does your child: Like sweets or crave sweets

If yes, what types? _____

Is your child active? Yes No

moderately? Yes No

extremely? Yes No

Are there periods of

very high energy? Yes No

very low energy? Yes No

Explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

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

If yes, explain: _____

Normal birth? Yes No

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

If yes, explain: _____

Birth weight: _____ Apgar scores at birth: _____ After 10 minutes: _____

Were forceps used? Yes No

Was there ever a 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? _____

Was your child active? Yes No

Speech: First words: _____ At what age: _____

Was early speech clear to others? Yes No

Is speech clear now? Yes No

VISUAL HISTORY

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

If so, Doctor's Name: _____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended? Yes No

If yes, what? _____

Are they used? Yes No If yes, when? _____

If not used, why not? _____

Date: _____ Dr's Initials: _____

Members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

At what age did you first notice or suspect that was an eye turning? _____

Did the eye begin turning - suddenly or gradually ?

Does the eye turn - in out up or down ? (check all that apply)

Is the eye turn getting worse or better, or is there no change? _____

Is it always the same eye that turns? Yes No

If yes, which eye? Right Left

Is the eye turn always present? Yes No

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) _____

Do you notice if the eye turns more when your child is looking:

up close? Yes No

in the distance? Yes No

to his/her left? Yes No

to his/her right? Yes No

up? Yes No

down? Yes No

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

Does the eye turn less when the prescription is worn? Yes No Unsure

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____

Have you ever been told that your child has amblyopia ("lazy eye")? Yes No

Has there been any surgical treatment? Yes No

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, and an estimate of the cosmetic and subjective results: _____

Were you satisfied with the results of surgery? Yes No

Please explain: _____

Was the surgeon satisfied with the results of surgery? Yes No

Please explain: _____

Are you here for a second opinion regarding surgery or further treatment? Yes No

Has there been any visual therapy? Yes No

If yes, Drs. name: _____

If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: _____

Date: _____ Dr's Initials: _____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed? _____

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes No

If yes, what? _____

DOES YOUR CHILD REPORT ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	_____

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

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	<u>Yes</u>	<u>If yes, when?</u>
Moves head when reading	<input type="checkbox"/>	_____
Skips, re-reads or omits words	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	_____
Eyes frequently reddened	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	_____
Focus goes in and out	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	_____
Reverses letter or words	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	_____

Date: _____ Dr's Initials: _____

- Vocalizes when reading silently _____
- Confuses right and left _____
- Poor reading comprehension _____
- Comprehension decreases over time _____
- Tires easily _____
- Difficulty recognizing same word on different page _____
- Poor word attack skills _____
- Difficulty with memory _____
- Remembers better what hears than sees _____
- Responds better orally than by writing _____
- Seems to know material, but 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 / hitting a ball _____
- Writes or prints poorly _____
- Writes neatly but slowly _____
- Does not support paper when writing _____
- Awkward or immature pencil grip _____
- Frequent erases _____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

- Does child watch TV? Yes No
- If yes, how much? _____ How often? _____ Viewing distance? _____
- Does your child spend time using computer/video games? Yes No
- If yes, how much? _____ How 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? _____
- Please explain: _____

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 often? 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 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: _____

Date: _____ Dr's Initials: _____

Does your child like to read? Yes No
Voluntarily? Yes No
Does your child read for pleasure? Yes No
What? _____

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

Overall schoolwork is: above average average below average

WHICH SUBJECTS ARE:

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 potential? Yes No

Does the teacher feel your child is achieving up to 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? sag 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? _____

Date: _____ Dr's Initials: _____

Did mother or anyone in mother's family have a learning problem? Yes No

If yes, who? _____

Do any, or did any, of the other children in the family have learning problems? Yes No

If yes, who? _____

To what extent? _____

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

Print Name: _____

Signature: _____

Date: _____ Dr's Initials: _____