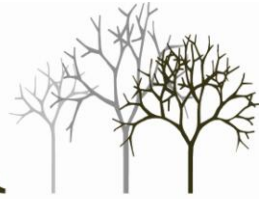


Alderwood



Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a comprehensive vision examination. On the following pages you will find a Returning Children's Vision Questionnaire and symptom checklist. **Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the examination.**

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.
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.

RETURNING CHILDREN'S VISION 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.**

Specifically is there any family history of:

	Patient	Family	Whom
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double-vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus(eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Patient	Family	Whom
Amblyopia(lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child report any of the following:

	Yes
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"/>

If yes, when?

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

Have you or anyone else ever noticed the following:

	Yes
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"/>

If yes, when?

Date: _____ Dr's Initials: _____

Difficulty copying from chalkboard

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

Horizontal lines for notes or observations.

Print Name: _____

Signature: _____

Date: _____ Dr's Initials: _____