

ALDERWOOD VISION THERAPY CENTER, PLLC

Drs. Torgerson, Murphy, Maher, & Hash

16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

Dr. Initials/Date: _____ / _____

INITIAL VISION QUESTIONNAIRE FOR SCHOOL-AGE

Appointment Date: ____ / ____ / ____

Full Legal Name: _____ Date of Birth: ____ / ____ / ____ Age: _____

Name your child prefers to go by: _____

GENERAL INFORMATION

Were you referred to our office? Yes No

By whom? _____ His/Her profession: _____

Referral address: _____ Referral Phone#: _____

May we update the referral source? Yes No

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:

Parent/Caretaker _____ Birth Date _____

Parent/Caretaker Occupation? _____ Employer _____

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Parent/Caretaker Occupation? _____ Employer _____

Sibling _____ Birth Date _____

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Sibling _____ Birth Date _____

PRESENT SITUATION

Why does your child need a visual evaluation? _____

Has the school/another professional expressed concern regarding your child's vision? Yes No

If yes, what concern? _____

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

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: _____

Does your child wear glasses, contact lenses, and/or use a special optical device? Yes No

If yes, what? _____

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

If not used, why not? _____

****For Your Information: We refer out for contact lens fitting, dispensing and follow-up.***

Has your child had eye surgery? Yes No

By Whom: _____ For what: _____

Members of the family who have had visual conditions:

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

MEDICAL HISTORY

Pediatrician's Name: _____

May we update your pediatrician? Yes No

Is your child generally healthy? Yes No

If no, explain: _____

Are there any chronic problems? Yes No

If yes, please list: _____

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

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

Does your child use a mobility aid? Yes No

If yes, what aid? (Circle) Wheelchair Walker Other: _____

Has your child been diagnosed on the autism spectrum? Yes No

Has your child had an acquired brain injury and/or concussion? Yes No

If yes, please explain: _____

Has a neurological evaluation been performed? Yes No

By whom? _____ Results: _____

Has a psychological evaluation been performed? Yes No

By whom? _____ Results: _____

Has an occupational / speech / physical therapy evaluation been performed? Yes No

By whom? _____ Results: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

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 Were forceps used? Yes No

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

If yes, explain: _____

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

If yes, why? _____

Did your child crawl? Yes No At what age? _____

At what age did your child walk? _____

Did your child frequently walk on his/her toes? Yes No

Is your child's speech clear to others? Yes No

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does your child watch TV? Yes No How often? _____ Viewing distance? _____

Does your child spend time using computer/video games? Yes No

If yes, how much? _____ How often? _____ Viewing distance? _____

Does your child spend time using small screen devices (ie. smart phones, tablets, handheld video games) Yes No If yes, how much? _____ How often? _____

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

Describe any school difficulties: _____

Has a grade been repeated? Yes No

If yes, which and why? _____

Does your child appear frustrated when doing school/homework? Yes No

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

If yes, when? _____

From whom and how long? _____

Results: _____

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 peers? _____

Which school subject 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 concerns at school or at home? Yes No

If yes, please explain: _____

FAMILY AND HOME

Please indicate which adult(s) your child lives with: _____

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 (ie. parental loss, divorce, separation, severe parental illness)? Yes No If yes, at what age: _____

Has anyone in the immediate family or extended family had a learning problem? Yes No

If yes, who? _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

Today's Date: ____ / ____ / ____

Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____