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 UNDER 5

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 _____
Parent/Caretaker _____Birth Date _____
Parent/Caretaker Occupation?_____Employer _____
Sibling _____Birth Date _____
Sibling _____Birth Date _____
Sibling _____Birth Date _____
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:

Name & Relationship	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

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.:

Age	Severe	Mild	Complications

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 an occupational/speech/physical therapy/psychological 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 _____
Does your child like school? Yes ☐ No ☐
Describe any school difficulties: _____
_____
Has your child had therapy? Yes ☐ No ☐
If yes, when? _____
From whom and how long? _____
Results: _____
Do you feel your child is developing and achieving up to his/her 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: _____