VISION CARE & THERAPY CENTER
12020 Etris Rd Suite B-100 Roswell, GA 30075 678.256.3990

JANNA IYER, O.D.
Clinical Director

CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. THANK YOU.

Appointment: Day _____ Date _____ Time _____

GENERAL INFORMATION

Were you referred to our office ? Yes ▫ No ▫

If yes whom may we thank for this referral? _____ Phone: _____

If no, how did you hear about us?_____

Child's Full Name: _____ Male ▫ Female ▫

Birth Date: _____ Age: _____years _____months

Name and address of school: _____

Grade: _____ Teacher: _____

Is your child especially afraid of doctors? _____

Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ▫ No ▫

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____Birth Date _____

Mother/Caretaker _____Birth Date _____

Sibling _____Birth Date _____

Sibling _____Birth Date _____

Sibling _____Birth Date _____

Sibling _____Birth Date _____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City:_____ Zip: _____

Home Phone: _____ Business Phone: _____

Father/Caretaker's Occupation: _____ Cell Phone: _____

Business Address: _____ City: _____ Zip: _____

Mother/Caretaker's Occupation: _____ Cell Phone: _____

Business Address: _____ City: _____ Zip: _____

Do you have Major Medical Insurance? Yes ▫ No ▫

If so, who is the carrier? _____ Policy #: _____

Name of Insured: _____

Social Security Number: _____ Driver's License #: _____

Email address:_____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

_____

Child's current state of health: _____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

_____

Food and/or drug allergies?_____

Are all immunizations up-to-date?_____

Any reactions to immunization(s)? Yes ▫ No ▫ If yes, explain: _____

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

Age Severe Mild Complications

_____

_____

_____

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 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 therapy evaluation been performed? Yes ▫ No ▫

By whom? Results and recommendations: _____

_____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	▫	▫	_____	High Blood Pressure	▫	▫	_____
"Cross" or "Wall" eye	▫	▫	_____	Learning Disability	▫	▫	_____
Chromosomal Imbalance	▫	▫	_____	Amblyopia (lazy eye)	▫	▫	_____
Glaucoma	▫	▫	_____	Multiple Sclerosis	▫	▫	_____
				Epilepsy or Seizures	▫	▫	_____
				Other	▫	▫	_____

If other, 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 @ birth: _____ After 10 minutes: _____

Were forceps used? Yes ▫ No ▫

Was there ever any 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 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? _____

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

Name	**Age**	**Visual Situation**
_____	____	_____
_____	____	_____
_____	____	_____

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?:	**Yes**	**No**	**If yes, when?**
Headaches	▫	▫	_____
Blurred vision / focus goes in and out	▫	▫	_____
Double vision	▫	▫	_____
Eyes hurt	▫	▫	_____
Eyes tired	▫	▫	_____
Words move around on the page	▫	▫	_____
Motion sickness / car sickness	▫	▫	_____
Dizziness	▫	▫	_____

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

_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	**No**	**If yes, when?**
Eyes frequently reddened	▫	▫	_____
Frequent eye rubbing	▫	▫	_____
Frequent sties	▫	▫	_____
Frowning	▫	▫	_____
Bothered by light	▫	▫	_____
Frequent blinking	▫	▫	_____
Closing or covering one eye	▫	▫	_____
Difficulty seeing distant objects	▫	▫	_____
Head close to paper when reading or writing	▫	▫	_____
Avoids reading	▫	▫	_____
Prefers being read to	▫	▫	_____
Tilts head when reading	▫	▫	_____
Tilts head when writing	▫	▫	_____
Moves head when reading	▫	▫	_____
Confuses letter or words	▫	▫	_____
Reverses letter or words	▫	▫	_____

Confuses right and left	□	□	_____
Skips, rereads or omits words	□	□	_____
Loses place while reading	□	□	_____
Vocalizes when reading silently	□	□	_____
Reads slowly	□	□	_____
Uses finger as a marker	□	□	_____
Poor reading comprehension	□	□	_____
Comprehension decreases over time	□	□	_____
Writes or prints poorly	□	□	_____
Writes neatly but slowly	□	□	_____
Does not support paper when writing	□	□	_____
Awkward or immature pencil grip	□	□	_____
Frequent erasures	□	□	_____
Tires easily	□	□	_____
Difficulty copying from chalkboard	□	□	_____
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	□	□	_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ 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 extreme 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: _____

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? _____

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: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of the VISION CARE & THERAPY CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize the VISION CARE & THERAPY CENTER to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment. I also agree that the report following this evaluation may be

e-mailed to me at _____.

_____ _____
Signature Date

_____
RELATIONSHIP TO PATIENT

I hereby give my permission to the VISION CARE & THERAPY CENTER to treat _____
(Child's Name)

_____ _____
Parent's or Guardian's Signature Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions on concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day /7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

THANK YOU.

SINCERELY,

Janna Iyer, O.D., F.C.O.V.D.
CLINICAL DIRECTOR