

The Center for Vision Development

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Thank you for carefully completing this questionnaire, to personalize your child's care.
Please return all forms at least 24 hours prior to your appointment by fax, email or regular mail.

Patient's Name: _____ Nickname: _____
Date of Birth: _____ Age Now: _____ Gender: Male Female
Were you referred to us? Yes No
If you were referred, whom may we thank? _____
Referral Type: Doctor Therapist Tutor/Teacher Family Friend Other: _____
If not referred, how did you hear about us? _____

YOUR CHILD'S CONTACT INFORMATION

Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Mother/Caretaker's Name: _____ Email: _____
Occupation: _____ Business Phone: _____ Cell Phone: _____
Father/Caretaker's Name: _____ Email: _____
Occupation: _____ Business Phone: _____ Cell Phone: _____
Preferred Contact: _____
Preferred Method of Contact: Home Phone Business Phone Cell Phone Email

YOUR CHILD'S MEDICAL HISTORY

Pediatrician's Name: _____ Is your child especially afraid of doctors? Yes No
Last Visit Date: _____ For what reason? _____ Is your child generally healthy? Yes No
Medications (include vitamins/supplements): _____

Does your child receive immunizations? Yes No

Please indicate if your child has problems with any of the below.

Event/Condition	Yes/No	Please describe, including time of onset
Constitutional symptoms (e.g. fever, weight loss)		
Hematologic (e.g. anemia)		
Allergic/immunologic		
Endocrine		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
Ears, nose, mouth or throat		
Gastrointestinal		
Skin disorders		
Musculoskeletal		
Genitourinary		

YOUR CHILD'S FAMILY HISTORY (Please check if there is any history of the following.)

	Patient	Family	If Family, Who?		Patient	Family	If Family, Who?
Poor Vision/Hi Rx				Diabetes			
Strabismus/ eye turn				High Blood Pressure			
Amblyopia (lazy eye)				Epilepsy or Seizures			
Glaucoma				Learning Issue			
Blindness				Other			

YOUR CHILD'S VISUAL HISTORY:

Has your child's vision been previously evaluated? Yes No If "Yes," Doctor's Name: _____

Date of Evaluation: _____ Results and recommendations: _____

Does your child wear: Glasses Contacts Both Worn for which activities? _____

Has your child failed a school vision screening? _____

Does your child have academic difficulties? _____

Check all that apply: Reading/reading comprehension Writing Increased time to do homework
Behavioral issue Not working up to potential Dyslexia ADD/ADHD Other _____

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

Please describe any other visual symptoms that you notice: _____

YOUR CHILD'S VISUAL HISTORY - EXTENDED

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 issue may be present? Yes No If "Yes," what? _____

Do you or your child notice any of the following? (Note: Many of these symptoms fall into more than one category.)

Prescription/Eye Focusing (Accommodation) Problem

- Blurry vision
- Difficulty focusing near/far (copying from chalkboard)
- Eyestrain, fatigue, headaches
- Frowns/squints or facial tension
- Red eyes or lids
- Excessive watering of eyes or eye rubbing
- Head close to paper when reading/writing
- Reading comprehension decreases with time

Eye Tracking (Ocular Motility) Problem

- Skip words when reading
- Must reread to understand, especially when tired
- Use finger or marker when reading
- Loses place when reading
- Head movements when reading

Eye Teaming (Binocularity) Problem

- One eye turns in/out (SEE ADDENDUM)
- See double, especially when tired
- Cover or close one eye when reading or writing
- Tilt or turns head
- Awkward posture when standing/reading/writing
- Eyestrain or fatigue, especially at end of day
- Letters or lines "float" "run together," or "jump around"

Visual Motor Problem

- Write or print poorly (crooked, poor spacing, up/down)
- Writes neatly but slowly
- Awkward pencil grip
- Poor eye-hand coordination
- Clumsy, accident-prone
- Difficulty judging distances or objects
- Dislike/avoid sports

Visual Information-Processing Problem

- Slow reader
- Confuses letters or words
- Difficulty recognizing same word on different page
- Mistakes words with similar beginnings
- Poor ability to remember what is read
- Seems to know material but does poorly on tests
- Reverses letters and numbers
- Learn better when "hear" the information
- Vocalizes or moves lips when reading silently
- Difficulty following verbal instructions
- Poor time management, always running behind
- Poor printing or handwriting
- Short attention span, distractible or loss of interest
- Confuse "right" and "left"
- Difficulty attending to detail

YOUR CHILD'S DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No If no, please explain: _____

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

Any pregnancy/delivery complications? Yes No If "Yes," explain:_____

Did your child crawl (stomach on floor)? Yes No At what age?_____ Anything unusual?_____

Did your child creep (stomach off floor)? Yes No At what age?_____ Anything unusual?_____

At what age did your child walk? _____ Speech: First words: _____ At what age:_____

Was early speech clear to others? Yes No Is speech clear now? Yes No

Child's dominant hand? Right Left Unknown

Has there been any concern over your child's general growth or development? Yes No

If "Yes," explain:_____

Have any of the following evaluations been performed?

Neurological evaluation? Yes No By whom?_____

Results and recommendations:_____

Psychological evaluation? Yes No By whom?_____

Results and recommendations:_____

Occupational therapy evaluation? Yes No By whom?_____

Results and recommendations:_____

Speech therapy evaluation? Yes No By whom?_____

Results and recommendations:_____

YOUR CHILD'S SCHOOL AND READING HABITS

Age at time of entrance to: Pre-school_____ Kindergarten_____ Current School Grade:_____

School Name:_____

Teacher Name:_____ School Nurse Name:_____

Principal Name:_____ In-School Educational Specialist Name:_____

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 like school? Yes No What parts?_____

Specifically describe any school difficulties:_____

Does your child seem to tense up 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?_____

What were the results:_____

Does your child like to read? Yes No Does your child read voluntarily? Yes No

If "Yes," 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? _____ hours

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

YOUR CHILD'S GENERAL BEHAVIOR

Are there any behavior problems at school? Yes No If "Yes," what are they and are there specific triggers? _____

Are there any behavior problems at home? Yes No If "Yes," what are they and are there specific triggers? _____

Child's reaction to fatigue? Sad Irritable Other _____

Child's reaction to tension? Avoidance Irritable Other _____

What best describes your child's activity level? Inactive Moderately active Extremely active

YOUR CHILD'S TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? Yes No Average viewing time? _____

Use computer? Yes No Average viewing time? _____

Play video games? Yes No Average viewing time? _____

What other activities occupy your child's leisure time? _____

Are there any activities your child would like to participate in, but doesn't? Yes No

Please explain: _____

YOUR CHILD'S NUTRITIONAL INFORMATION

Any foods your child especially likes? _____

Any foods your child especially dislikes? _____

Has your child tested positive for food allergies or sensitivities? Yes No If so, which foods? _____

YOUR CHILD'S 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: _____

Does your child spend a significant amount of time with any other person, not in the home? Yes No

Please explain: _____

Does the child have any siblings? Yes No Names and ages? _____

Has your child ever been through a traumatic family situation (separation/divorce, parental loss, separation from parents, severe parental illness)? Yes No Please explain: _____

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: _____

Does your child get along well with: Parents/other caretakers? Yes No Siblings? Yes No

Classmates in school? Yes No Playmates at home? Yes No

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

WHAT ARE YOUR BIGGEST CONCERNS REGARDING YOUR CHILD AT THIS TIME? _____

WHAT IS YOUR GOAL FOR YOUR CHILD'S VISUAL EVALUATION AND/OR VISION THERAPY? _____

If you have any questions or concerns that we may answer prior to your appointment, please contact us.

We are looking forward to meeting you!

Sincerely,

Christina M. Danley, O.D.
Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills used for improved performance in school, work and sports/hobbies, providing a more enjoyable quality of life.

STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you ever been told that your child has amblyopia ("lazy eye")? Yes No If "Yes," at what age? _____

Have you ever been told that your child has strabismus ("eye turn")? Yes No If "Yes," at what age? _____

Have your child had an eye surgery? Yes No If "Yes," please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on: _____

Was the surgeon satisfied with the results of surgery? Yes No Explain: _____

Were you satisfied with the results of surgery? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

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

IF YOUR CHILD'S EYE TURNS:

- At what age did you first notice or suspect that was an eye turning? _____
- Did it begin turning: suddenly or gradually ? Explain: _____
(Note: A sudden eye turn may be due a serious medical emergency and requires immediate medical attention.)
- 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 no, under what conditions is it present? _____
- Does the eye always turn the same amount? Yes No
 - If no, explain: _____
- Do you notice if the eye turns more when your child is looking:
 - up close? Yes No
 - in the distance? Yes No
 - to the left? Yes No
 - to the right? Yes No
 - up? Yes No
 - down? Yes No

Does the eye turn less (or vision improve) when the prescription is worn? Yes No Unsure

Has your child ever used an eye patch? Yes No

If "Yes," please describe your child's age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: _____

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

What is your child's best corrected vision, if known? _____

What are your biggest concerns regarding your child's strabismus or amblyopia? _____

Release of Information

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CHILD'S CARE, *WITH YOUR PERMISSION*. 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 other health care providers upon their written request or upon the recommendation of the The Center for Vision Development when it is necessary for the treatment of my child's visual condition. I authorize Dr. Christina Danley and The Center for Vision Development to exchange information with 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.

Signature

Date

Relationship to Patient

I hereby give my permission to The Center for Vision Development to treat _____.
Child's Name

Parent's or Guardian's Signature

Date