

The Center for Vision Development

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Thank you for carefully completing this questionnaire, to personalize your 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? _____

CONTACT INFORMATION

Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email: _____
Occupation: _____ Business Phone: _____
Preferred Method of Contact: Home Phone Business Phone Cell Phone Email
Person to Contact in Case of Emergency: _____ Phone: _____

MEDICAL HISTORY

Physician's Name: _____ Date of most recent visit: _____
For what problem/condition? _____
Medications (include vitamins/supplements): _____

Are you allergic to any medications? Yes No If "Yes," please list: _____

Please indicate if you have 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		

List any major illnesses, injuries, surgeries, or hospitalizations: _____

YOUR NUTRITIONAL INFORMATION

Any foods you especially like? _____

Any foods you especially dislike? _____

Have you tested positive for food allergies or sensitivities? Yes No If so, which foods? _____

MEDICAL HISTORY - EXTENDED

Did you experience any developmental (i.e. age to crawl/walk/talk) or learning delays? 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: _____

Chiropractic evaluation? Yes No By whom? _____

Results and recommendations: _____

FAMILY MEDICAL 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				Cancer			
Blindness				Other			

YOUR VISUAL HISTORY:

Why do you feel the need for a visual evaluation? _____

How long has this problem/difficulty existed? _____

Do you feel your vision hinders your daily activities in any way? Yes No

If "Yes," explain: _____

Do you feel your vision limits your potential in any way? Yes No

If "Yes," explain: _____

Have you had a previous vision examination? Yes No If "Yes," Doctor's name: _____

Date of evaluation: _____ Results and recommendations: _____

Do you wear: Glasses Contacts Both Worn for which activities? _____

Have you ever had vision therapy? Yes No

Doctor's name and city: _____

Please describe the age at which you started, how long you participated, and an estimate of results: _____

Do you notice any of the following visual symptoms? (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

READING/COMPUTERS

Do you like to read? Yes No

How long are you able to read until your eyes bother you? _____

Do you use a computer in your work, school or leisure time activities? Yes No

What type of computer work do you perform? Word processing Programming Data entry
Internet Games/Leisure activities Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

Do any of the following body parts ache/hurt after working on the computer? Neck Face Back Arm

Hand Leg Other (explain): _____

Describe the sensation: _____

EMPLOYMENT OR SCHOOL

Current position or Major course of study: _____

Briefly describe your daily activities at work or in school: _____

What are your biggest challenges with these activities? _____

How many hours daily to spend at a desk? _____ Working at near distances? _____

Do you feel you are achieving your potential in work or school? Yes No

Do you feel an increasing need for more effort to accomplish tasks? Yes No

If "Yes," please explain: _____

HOBBIES/SPORTS

Describe the types of activities you like to do in your leisure time: _____

Do you watch TV? Yes No Average viewing time? _____

Do you participate in sports or outdoor activities? Yes No

Do you feel challenged or uncoordinated in sports or athletic activities? Yes No

Of all the sports you have played, list the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

GIVE A BRIEF DESCRIPTION OF YOURSELF AS A PERSON: _____

WHAT IS YOUR GOAL FOR THIS VISION EVALUATION AND/OR VISION THERAPY? _____

WHAT IS THERE ANY FURTHER INFORMATION YOU WOULD LIKE TO PROVIDE TO ASSIST IN YOUR VISION MANAGEMENT? _____

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 you have amblyopia ("lazy eye")? Yes No If "Yes," at what age? _____

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

Have you 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 EYE TURNS:

- 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

Have you ever used an eye patch? Yes No

If "Yes," please describe your 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 best corrected vision, if known? _____

What are your biggest concerns regarding your 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 CARE, *WITH YOUR PERMISSION*. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my examination records to be forwarded to 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 visual condition. I authorize Dr. Christina Danley and The Center for Vision Development to exchange information with other professionals involved in my care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Signature

Date

Print Name