Vision Development Institute, P.C.
Hans F. Lessmann, O.D., F.C.O.V.D.
Towne Centre Offices Suite 130
1789 South Braddock Avenue
Pittsburgh PA 15218

Phone (412) 731-5007
FAX (412) 731-5251

Thank you very much for your interest in the Vision Development Institute. Enclosed you will find a patient history questionnaire.

Please return all of the attached forms as they may apply to your case to our office so that we can have time to review your case and make any calls before your scheduled appointment.

Please anticipate weather and local traffic conditions and plan to arrive approximately 15 minutes before your scheduled time on this first visit.

If you have not already done so, please send a $25.00 Registration Fee to the above address immediately, to reserve your scheduled time. This non-refundable deposit will then be applied to the total fee, leaving the balance due and payable at the time of the exam.

An audio taped summary of your conference will be provided upon request. There is an additional fee for any written reports, if you request them.

Please be sure to attach a current photo in the appropriate spot on the form provided.

We look forward to working with you in what appears to be a very interesting case.

Sincerely,

THE VISION DEVELOPMENT INSTITUTE

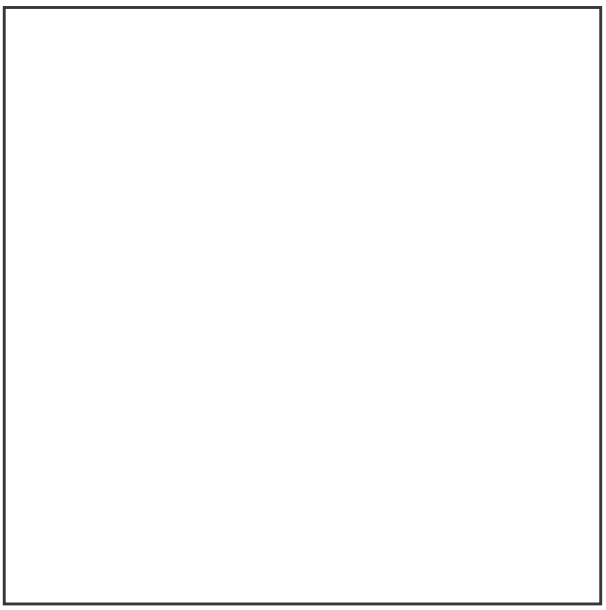
NOTE: If you are covered by health insurance, please bring a completed form and/or your insurance ID cards with you. (A Major Medical Form if Comprehensive Blue Cross and Blue Shield). All fees are due and payable at the time of the evaluation by check, cash, Debit card, MasterCard, Visa, Discover or American Express.

Vision
Development Institute, P.C.

Hans F. Lessmann, O.D., F.C.O.V.D., F.C.S.O.

INTRODUCING ...

Patient s Name: _____



Please attach a recent photo here.

Email address: _____

Please send, prior to your appointment if possible, otherwise bring with you to the initial visit any reports from doctors or clinics or school that you may be able to share with our staff.

Towne Centre Offices Suite 130 1789 S. Braddock Ave. Pittsburgh, PA 15218-1871
(412) 731-5007 FAX (412) 731-5251 email: visiondevelopment1992@yahoo.com www.optometrists.org/lessmann
Board certified in vision & light therapy

VISION DEVELOPMENT INSTITUTE

Towne Centre Offices, 1789 S. Braddock Ave Pittsburgh PA 15218
Phone (412) 731-5007 FAX (412) 731-5251

The information requested below is desired for the sole purpose of gaining an understanding of the applicant. Please answer all questions that are applicable as fully as possible and return this form to the above address. Your responses will remain confidential.

Applicant's Name

Sex Age Birth Date

Father Phone (H) (W)

Mother Phone (H) (W)

Home Address

City State Zipcode

School Name and Address Grade

Who Referred You:

Specific Reason For Referral:

What do you want to find out from the exam:

Family History	Mother	Father
Occupation:		
Birth Place:		
Marital Status: (dates)	Married	Married
	Divorced	Divorced
	Remarried	Remarried
	Widow	Widower
General Health:		

	Mother	Father
Highest Grade Completed:		
Any Educational Difficulties:	Yes No	Yes No
If yes, describe:		

Language spoken in home:

Other Languages:

Brothers and Sisters	Oldest	Next Oldest	Next	Next
Age				
Sex				
Grade Completed				
Any Educational Difficulties?				
If yes, describe:				

DEVELOPMENTAL HISTORY

Is applicant adopted? If yes, does applicant know this?

Age when adopted? Was pregnancy full term?

Any complications before, after or during delivery? If so, describe:

Did the following occur later than the expected time?

First Tooth Creeping Crawling

Sitting Alone Walking Alone Feeding Self

Voluntary control of Bladder Toilet Training

When did Child show tendency to establish handedness?

Has anyone attempted to change applicant's handedness?

MEDICAL HISTORY

Has child had any serious accidents, operations or unusual illnesses such as high-fever, prolonged confinement, etc. ? If so, please specify accidents and/or illnesses and the DATES they occurred:

Please state any existent allergies:

When was child's last physical examination? Any chronic problems?

Taking medication, if so what?

Has child been referred to neurologist? If so, for what reason?

Has child, or family been referred for counseling? If so, for what reason?

Was the therapy successful? Comment:

VISUAL HISTORY:

Has there been previous visual care? If so, by whom and when?

Were glasses prescribed? Does child wear glasses without urging?

Does child report headaches? When?

Does child report eyes "hurt/tired"? When?

Does child report blurred vision? When?

Does child report seeing "double"? When?

Does child report blur at distance? When?

Does child report blur at near/ reading? When?

Do bright lights bother child? When?

Are child's eyes frequently bloodshot? When?

Are there frequent Styes? Which Eye?

Does child rub his/her eyes? When?

Does child blink excessively? When?

Does child like to read? Yes No

How much does child read? Least Most

Does child reverse words or letters	Yes	No
Does child skip words or re-read	Yes	No
Does child move lips when reading to self:	Yes	No
Does child move head while reading?	Yes	No
Does child tilt head while reading?	Yes	No
Does child frown or squint at reading or TV?	Yes	No
Does child use finger to follow words?	Yes	No
Does child hold book too close while reading?	Yes	No
Does child read as well as others in same grade?	Yes	No

LANGUAGE DEVELOPMENT SKILLS:

At what age did child speak first sentence? (i.e. daddy hurt finger, mama kick ball) _____
At what age did child ask first question? (i.e. mama doing ? ? ?) _____
What was child's first "why?" _____ At what age? _____
Does child have a speech of language deficit ? _____ If so has attempt been made to correct? _____
By whom? _____
Was the therapy successful? _____ Comments: _____

SLEEP PATTERNS:

Does child require a lot of sleep? _____
Does child sleep soundly? _____
What are the usual hours of sleep? From _____ to _____
Does child awaken fresh and rested? _____
Does fatigue result in sag, excitability or irritability? _____

EATING HABITS:

Is child a good eater ? _____
Is intake low, medium or large ? _____
Does your child take vitamin supplements? _____
Describe:_____
Is there a good variety of nutritious foods? _____
Is there a high desire for sweets? _____
Is there a high desire for 'junk foods' ? _____

FAMILY AND HOME SITUATIONS:

State any symptoms of anxiety such as nail-biting, eye blinking, or excessive eye rubbing, or tantrums, etc.

What type of discipline is most effective in guiding your child?

What adults besides the parents play an active part in guiding your child?

What responsibilities does your child have at home?

Can child carry out responsibilities alone?		Does child need reminders?
Does child have any outside job?	Paid or volunteer?	If so, what?
Describe the special interests of child:		

SCHOOL ADJUSTMENT:

Please list the schools child has attended:

Name	Location	Grade Level

Indicate child's general achievement in school:

Grade Level	Very Poor	Poor	Average	Above Average

Does child like school? _____ Is attendance regular? _____
Has child ever been retained? _____ If yes, what grade(s)? _____
How did child react to retention?

What is the structure of the school (traditional or open classroom)?

Are there subjects that child likes more than others? If so, list:

Has child ever received special help in reading or math?

How do you feel your child performs in each of the following areas:

reading comprehension
reading retention
reading rate
spelling
handwriting
expressing thoughts verbally
expressing thoughts in writing
math concepts
math computation
attention span
ability to follow written directions
ability to follow verbal directions

Does child memorize answers or think through problems to obtain a solution?

What is child's general attitude toward present school and teachers? (likes, dislikes, indifferent, etc)

Type of teacher to whom child is most responsive? (i.e. male, female, strict, flexible)

How would you rate child's popularity among classmates? (ignored, rejected, accepted, has many friends of both sexes, etc.)

What age child does your child prefer to work and play with?

Older Same Younger What sex

Does the school consider your child to have a learning problem? Discuss:

PREVIOUS TESTING:

Type of testing:

Date(s) of testing:

Administered by whom?

Results or recommendations?

Does test taking appear to cause anxiety?

GENERAL MOVEMENT DEVELOPMENT:

Is child physically active?

List team sports:

List individual sports:

Can child throw a ball? Catch a ball?

Would you consider child to have good rhythm?

Is child "klutzy" or clumsy? Coordinated?

Do you consider child's general movement to be age appropriate?

BEHAVIORAL CHARACTERISTICS:

Following is a list of characteristics which can often be observed. Please circle the most appropriate response for each item as it relates to your child.

Blames others for troubles	Always	Usually	Rarely	Never	Don't Know.
Cries	Often	At Times	Rarely	Never	Don't Know
Daydreams	Often	At Times	Rarely	Never	Don't Know
Is friendly	Always	Usually	Rarely	Never	Don't Know
Gets in fights	Often	At Times	Rarely	Never	Don't Know
Is happy, light-hearted	Always	Usually	Rarely	Never	Don't Know
Must prod to get things done	Always	Usually	Rarely	Never	Don't Know
Follows through on tasks	Always	Usually	Rarely	Never	Don't Know
Listens to reason	Always	Usually	Rarely	Never	Don't Know
Is nervous, irritable	Always	Usually	Rarely	Never	Don't Know
Obeys	Always	Usually	Rarely	Never	Don't Know
Is honest	Always	Usually	Rarely	Never	Don't Know

Talks back	Always	Usually	Rarely	Never	Don't Know
Has temper tantrums	Often	At Times	Rarely	Never	Don't Know
Is timid , shy	Always	Usually	Rarely	Never	Don't Know
Has strong fears	Many	Some	Few	None	Don't Know
Becomes discouraged	Easily	At Times	Rarely	Never	Don't Know
Is dominated by other children	Often	At Times	Rarely	Never	Don't Know
Takes lead with peers	Often	At Times	Rarely	Never	Don't Know

Please describe any other characteristic(s) of your child that we should be aware of, in order to meet his or her needs as fully as possible:

Your Signature Relationship to applicant Date

PLEASE RETURN PROMPTLY TO: School-Age DEVA history form

VISION DEVELOPMENT INSTITUTE

Towne Centre Offices, 1789 S. Braddock Ave Pittsburgh PA 15218

Phone (412) 731-5007 FAX (412) 731-5251

Enclosures

Vision Development Institute, P.C.

Lifestyle Checklist

Name:_____ H C S _____ PRE POST INTERIM

Please assign a value between 0 and 4 for each symptom.
0=never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

	date				
1	Blurred vision at near				
2	Double vision				
3	Headaches associated with near work				
4	Words run together when reading				
5	Burning, stinging, watery eyes				
6	Falling asleep when reading				
7	Vision worse at the end of the day				
8	Skipping or repeating lines when reading				
9	Dizziness or nausea associated with near work				
10	Head tilt or closing one eye when reading				
11	Difficulty copying from the chalkboard				
12	Avoidance of reading and near work				
13	Omitting small words when reading				
14	Writing uphill or downhill				
15	Mis-aligning digits in columns of numbers				
16	Reading comprehension declining over time				
17	Inconsistent/poor sports performance				
18	Holding reading material too close				
19	Short attention span				
20	Difficulty completing assignments in reasonable time				
21	Saying I can t before trying				
22	Avoiding sports and games				
23	Difficulty with hand tools-scissors, calculator, keys, etc.				
24	Inability to estimate distances accurately				
25	Tendency to knock things over on desk or table				
26	Difficulty with time management				
27	Difficulty with money concepts, making change				
28	Misplaces or loses papers, objects, belongings				
29	Car sickness/motion sickness				
30	Forgetful, poor memory				
	Total Score				

Towne Centre Offices Suite 130 1789 S. Braddock Ave. Pittsburgh, PA 15218-1871
(412) 731-5007 FAX (412) 731-5251 email: visiondevelopment1992@yahoo.com www.optometrists.org/lessmann
Board certified in vision & light therapy

POST-CONCUSSION SYMPTOM SCALE

Please use the following scale to rate each symptom:

None		Mild		Moderate		Severe
0	1	2	3	4	5	6

SYMPTOMS	SEVERITY RATING						
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Headache							
Nausea							
Vomiting							
Balance Problems							
Dizziness (spinning or movement sensation)							
Lightheadedness							
Fatigue							
Trouble falling asleep							
Sleeping more than usual							
Sleeping less than usual							
Drowsiness							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervous/ Anxious							
Feeling more emotional							
Numbness or tingling							
Feeling slowed down							
Feeling like "in a fog"							
Difficulty concentrating							
Difficulty remembering							
Visual problems							
Other							
Total							

Directions to Edgewood Towne Centre
Vision Development Institute, PC
1789 S. Braddock Ave, Ste 130, Pittsburgh PA 15218 – 412-731-5007

The Towne Centre Offices, in the Edgewood Towne Center shopping complex, is a five-story brown brick building that is next to PNC Bank, and Giant Eagle. Our office is on the first floor through the front entrance and we are the only suite #130 before you go up the elevator. Free Parking. Many shops, restaurants, and fast food can be found in the Edgewood Towne Centre. Before 8:00 AM and after 5 PM weekdays, and 24 hours on weekends, the building is secured. You will be asked to sign in by the security guard if you enter during those times. If the front door is locked, please knock to get the attention of the security guard.

From The North (also see From the West below for I-79, 279,579)

Routes 8 and 28: use Washington Blvd. turn left onto Penn Avenue and then turn right on S. Braddock Avenue at the Shell gas station. Follow S. Braddock Avenue past Frick Park and Forbes Avenue through Regent Square, under the Parkway to the Edgewood Towne Centre Offices on the left. See additional detail above.

From the South

Route 837 to the Rankin Bridge – head straight through the traffic light and up the hill to the second light onto Braddock Avenue. Stay on Braddock through two stop signs and three traffic lights and be in the left lane at the Arby's restaurant. Jog left, then down and under the railroad tracks. Towne Centre Office building will be immediately to your right.

From the East

Follow the Parkway East inbound (I-376 West) to exit 7 Edgewood/Swissvale. At the end of the off-ramp, turn left onto S. Braddock Avenue, keeping in the left/center lane up to the hill. At the 2nd light turn left into Edgewood Towne Centre and park to the right of Giant Eagle. See additional detail above.

From the West (Airport, I-279, I-376 E, I-79, I-579 N)

Enter the city, getting onto the Parkway East (I-376 E to Monroeville) from the Fort Pitt Bridge or Blvd. of the Allies. Continue on I-376 E through the Squirrel Hill Tunnels and take Exit 7 Edgewood/Swissvale. Upon exiting, bear right toward Swissvale and turn left at the stop sign. At the BP station at the bottom of the hill, turn right onto S. Braddock Avenue. Keep in the center lane up the grade to the second traffic light. Turn left from the center-left lane then right at the Giant Eagle toward Towne Centre Offices.