CYPRESS VISION THERAPY

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CHILDREN'S VISION QUESTIONNAIRE

Child's Full Name: _____
Preferred Name: _____
Birth Date: _____ Age: _____ years Gender: _____
School: _____ Grade: _____
Teacher: _____ School Nurse: _____ Principal: _____
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 □

GENERAL INFORMATION

Were you referred to our office ? Yes □ No □
If yes, whom may we thank for this referral? _____
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: _____
Father/Caretaker's Occupation: _____
Cell Phone: _____ Email: _____
Mother/Caretaker's Occupation: _____
Cell Phone: _____ Email: _____

Do you have Major Medical Insurance? Yes □ No □
If so, who is the carrier? _____ Policy #: _____
Name of Insured: _____ Last 4 of Social Security Number: _____

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)? _____
Any reactions to immunization(s)? Yes □ No □ If yes, explain: _____
List illnesses, bad falls, high fevers, etc.:

Condition	Age	Severity	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: _____
Has your child ever had a diagnosed or suspected concussion? Yes □ No □
If yes, explain: _____

Is there any history of the following?

	Patient	**Family**	**Who?**
Diabetes	□	□	_____
High Blood Pressure	□	□	_____
Glaucoma	□	□	_____
Strabismus or Eye Turn	□	□	_____
Amblyopia or Lazy Eye	□	□	_____
Multiple Sclerosis	□	□	_____
Epilepsy or Seizures	□	□	_____
Chromosomal Imbalance	□	□	_____
Learning Disability	□	□	_____
Other	□	□	_____

If other, please explain: _____

NUTRITIONAL INFORMATION
Current Diet: Excellent □ Good □ Fair □ Poor □
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: _____

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? _____

At what age did your child walk? _____

Was child active? Yes □ No □

At what age did your child start talking? _____

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 problems:

Relationship to Patient Age Problem

_____

_____

_____

_____

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 noticed the following?:	Yes	No	If yes, when?
Eyes frequently reddened	□	□	_____
Frequent eye rubbing	□	□	_____
Frequent styes	□	□	_____
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 your child spend time playing video games? Yes □ No □
If yes, how much time daily? _____ How often? _____
Does your child have a phone, tablet, or ipad? (circle which)
How much time do they spend on it daily? _____
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

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/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, and peers? _____

_____

Overall schoolwork is: above average □ average □ below average □

Which subject 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 the father or anyone in the father's family have a learning problem? Yes □ No □

If yes, who? _____

Did the mother or anyone in the 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

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 upon their written request or upon the recommendation of Cypress Vision Therapy when it is necessary for the treatment of my child's visual condition. I authorize Dr. Pitts and Cypress Vision Therapy 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.

_____ _____

Signature Date

I hereby give my permission to Cypress Vision Therapy to treat _____
(Child's Name)

_____ _____

Parent's or Guardian's Signature Date

INFORMATION AND REPORTS FROM YOUR CHILD'S EXAMS MAY BE EMAILED TO YOU, PLEASE SIGN BELOW TO AUTHORIZE US TO EMAIL YOU MEDICAL INFORMATION REGARDING YOUR CHILD.

_____ _____

Signature Date

I have read and understood the consent and patient release forms above and agree to abide by their terms.

Guarantor's Name (please print): _____ **Date:**_____

Guarantor'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 to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or 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,

Erin Pitts, OD