OPTOMETRY, P.C.

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VISUAL INFORMATION PROCESSING EVALUATION (Child)

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day ________________ Date __________________ Time ______________

Patient's Name: ____

GENERAL INFORMATION

Were you referred? Yes _____ No _____

If yes, by whom? ________________________Phone: ______________

Address: ____

Child's Full Name: ________________________ Nickname ______________

Male ____ Female ____ Birth Date: __________________ Age: ______ years _____ months

Name and address of school: ________________________________

Grade ____ Teacher __________________ Principal ____________________

Is your child especially afraid of doctors? Yes or No (please circle) Child's handedness: Right or Left (please circle)

HOME: Father/Guardian ____________________ Birth Date ________________

Mother/Guardian ____________________ Birth Date ________________

Sibling(s) ____________________ Birth Date ________________

____________________ Birth Date ________________

____________________ Birth Date ________________

PARENT INFORMATION

***Please Circle:* Mother Father Both Other** ____________________________

Home Address ________________________ City ______________ Zip__________

Home Phone________________________ Cell Phone ____________________

Occupation________________________ Email Address __________________

***Please Circle:* Mother Father Both Other** ____________________________

Home Address ________________________ City ______________ Zip__________

Home Phone________________________ Cell Phone ____________________

Occupation________________________ Email Address __________________

Do you have Major Medical Insurance? ______________ Do you have a flex spending account? Y N

If so, who is the carrier? ____________________ Policy # ____________________

Name of Insured: ____

Social Security Number (last 4 #'s) ________________ Driver's License No. ______________

MEDICAL HISTORY

Physician's Name ____ Date of Last Visit _________________________

Results ____

Medications currently using____

For what condition? ____

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

	Child	Family		Child	Family
High Blood Pressure	______	______	Glaucoma	______	______
Diabetes	______	______	Cataract	______	______
Thyroid Condition	______	______	Blindness	______	______
Multiple Sclerosis	______	______	Strabismus	______	______
Brain Tumor	______	______	Amblyopia	______	______
Stroke	______	______	Chromosomal Imbalance	______	______

List illnesses, bad falls, high fevers, ear infections, concussions, head injuries, eye injuries, etc.:

Age	Severe	Mild	Complications

Is your child generally healthy?... Yes ______ No ______

Are there any chronic problems like ear infections, asthma, hay fever, allergies? .... Yes ______ No ______

If yes, please list ____

Has a speech / language evaluation been performed?.. Yes ______ No ______

By whom? ______________________________________ When? ______________________________________

Results____

Has an occupational therapy evaluation been performed?..................................... Yes ______ No ______

By whom? ______________________________________ When? ______________________________________

Results____

Has a physical therapy evaluation been performed? .... Yes ______ No ______

By whom? ______________________________________ When? ______________________________________

Results____

Has a neurological evaluation been performed? .... Yes ______ No ______

By whom? ______________________________________ When? ______________________________________

Results____

Has a psychological evaluation been performed?.. Yes ______ No ______

By whom? ______________________________________ When? ______________________________________

Results____

DEVELOPMENTAL HISTORY

Full-term pregnancy? .... Yes ______ No ______

Normal birth? .... Yes ______ No ______

Any complications before, during or immediately following delivery? .... Yes ______ No ______

If yes, please explain ____

Did your child crawl (stomach on floor)? Yes ______ No ______ At What Age? ______________

Did your child creep (stomach off floor)? Yes ______ No ______ At What Age? ______________

If not, describe ____

At what age did your child walk? ____________________ Was your child active?........Yes ______ No ______

Speech: First words at age ____________________ Was your child alert as an infant? Yes ______ No ______

Was early speech clear to others? Yes ______ No ______ Is it clear now?................Yes ______ No ______

NUTRITIONAL INFORMATION

Current Diet: Varied ________ Picky? ________ Supplements ________ Food allergies ________

Does your child:

like sweets .... Yes ______ No ______

crave sweets.. Yes ______ No ______

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 ______

PREVIOUS VISION EXAMINATIONS

Has your child had a previous vision examination? .... Yes ______ No ______

Date of last visit: ____

Reason for examination: ____

Results: ____

Were glasses or contact lenses ever prescribed?............................ Yes ______ No ______

If yes, Bifocal? __________ Single-vision? __________ Date Prescribed ______________

Are they worn? .... Yes ______ No ______

When are they worn? ____

Are they for distance?... Yes ______ No ______

Are they for near?.. Yes ______ No ______

Are they for full-time use?... Yes ______ No ______

Was Vision Therapy prescribed .... Yes ______ No ______

Was Vision Therapy done? .... Yes ______ No ______

If yes, for how long? ____

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

Name	Age	Visual Situation

PRESENT SITUATION

Is there any evidence from the school, psychological, pediatric, occupational therapy, or speech/language tests that indicate some visual malfunction may be present? Yes ______ No _______

If yes, what?____

____

Does your child experience any of the following?:	Yes	No	If yes, when?
Headaches	_____	_____	______________________________
Blurred vision	_____	_____	______________________________
Double vision	_____	_____	______________________________
Eyes “feel tired”, “ache” or “hurt”	_____	_____	______________________________
They fatigue easily	_____	_____	______________________________
Brightness is bothersome	_____	_____	______________________________
Fluorescent lights are bothersome	_____	_____	______________________________
Patterned wallpaper or carpets are bothersome	_____	_____	______________________________
Grocery stores or malls are difficult to be in	_____	_____	______________________________
Movement of objects in the environment is bothersome or distracting	_____	_____	______________________________
There is difficulty with peripheral vision	_____	_____	______________________________
One eye turns in, out, up or down	_____	_____	______________________________
Squinting, covering or closing one of their eyes	_____	_____	______________________________
Frequently blinking	_____	_____	______________________________
Frequently rubbing eyes	_____	_____	______________________________
Frequently reddened eyes	_____	_____	______________________________
Eyes itch	_____	_____	______________________________
Excess mucus or tears	_____	_____	______________________________
Motion sickness or dizziness (circle one or both)	_____	_____	______________________________
Uncomfortable watching 3-D movies	_____	_____	______________________________
They dislike heights	_____	_____	______________________________
Difficulty catching or hitting a ball	_____	_____	______________________________
Poor motor or balance coordination	_____	_____	______________________________
Difficulty using both sides of the body together	_____	_____	______________________________
Delayed dressing skills	_____	_____	______________________________
Moving their head close to paper when reading or writing	_____	_____	______________________________
Tilting their head when reading or writing	_____	_____	______________________________
Their head moves when reading	_____	_____	______________________________
Confusing letters or words (circle one or both)	_____	_____	______________________________
Reversing letters or words (circle one or both)	_____	_____	______________________________
Words appear to move around on the page	_____	_____	______________________________
Skipping, rereading or omitting words (circle)	_____	_____	______________________________
They lose their place while reading	_____	_____	______________________________
They use their finger as a marker when reading	_____	_____	______________________________

HAVE YOU EVER NOTICED THE FOLLOWING?:

	Yes	No	If yes, when?
Vocalizing when they are reading silently	_____	_____	________________________________
Reading slowly	_____	_____	________________________________
Poor reading comprehension	_____	_____	________________________________
There are memory difficulties	_____	_____	________________________________
Difficulty following a series of directions	_____	_____	________________________________
Short attention span when reading or writing	_____	_____	________________________________
Poor spelling	_____	_____	________________________________
Writing or printing poorly	_____	_____	________________________________
They orient drawings poorly on the page	_____	_____	________________________________
Difficulty copying from the board at school	_____	_____	________________________________
Difficulty completing their assignments	_____	_____	________________________________
Avoiding activities that are within arm's reach (e.g. legos)	_____	_____	________________________________

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

____

____

Does their vision interfere with activities of daily living? .... Yes ______ No ______

If yes, please explain: ____

____

"SCREEN TIME"

This is the amount of time your child looks at a TV, computer, iPad or tablet, "Smart Phone", Kindle, etc.

Academic time:	Days per week_______	Hours per day____	Distance from eyes to screen_______
Recreational:	Days per week_______	Hours per day____	Distance from eyes to screen_______
Social/texting:	Days per week_______	Hours per day____	Distance from eyes to screen_______

Does your child have access to recreational or social "screen time" while doing homework? Yes _____ No _____

What are the total hours your child is in front of a screen? Hours per day_____

Is there visual or physical discomfort with computer use? Yes _____ No _____

SCHOOL

Your child's age at time they entered: Kindergarten ___________________ First Grade ___________________

Does your child like school? .... Yes _____ No _____

Has your child changed schools often?.. Yes _____ No _____

If yes, when? ____

Has a grade been repeated?... Yes _____ No _____

If yes, which? ____

Does your child seem to be under tension or pressure when doing their schoolwork?...... Yes _____ No _____

Does your child avoid their homework? .... Yes _____ No _____

Does your child take too long to do their homework?... Yes _____ No _____

Has your child had any special tutoring and/or remedial assistance?......................... Yes _____ No _____

If yes, when? ____________________

From whom? ____________________

Where? ____________________

How long? ____________________

Result: ____________________

What school subjects are easy for your child? ____________________

What school subjects are difficult for your child? ____________________

Does your child like to read? Yes _____ No _____ Does your child like to be read to? Yes _____ No _____

Does your child read voluntarily? Yes ______ No ______ What do they like to read? ____________________

Specifically describe any school difficulties: ____________________

____

What is your child's attitude toward reading, school, teachers and other youngsters? ____________________

____

Does your child have an I.E.P.? Yes _____ No_____ A 504 Plan? Yes _____ No _____

Do you have an Advocate? Yes _____ No _____ Who? ____________________

School work is: Above average ______ Average ______ Below average ______

Do you feel your child is achieving up to potential?... Yes _____ No _____

Does your child's teacher feel your child is achieving up to potential? .... Yes _____ No _____

GENERAL BEHAVIOR

Are there any behavior problems at school?.. Yes _____ No _____

Are there any behavior problems at home?.. Yes _____ No _____

What causes these problems? ____________________

Your child's reaction to fatigue? sag _____ irritable _____ other ____________________

Your child's reaction to tension? nail-biting _____ thumb-sucking _____ 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) your child lives with.

Mother _____ Father _____ Stepmother _____ Stepfather _____ Foster Parents _____

Adoptive Parents _____ Grandmother _____ Grandfather _____ Aunt _____ Uncle _____

Other ____________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? .... Yes _____ No _____

What age was (s)he? ____________________

Does your child seem to have adjusted?.. Yes _____ No _____

Is family life stable at this time? .... Yes _____ No _____

How does your child get along with:

Parents? ____________________

Siblings? ____________________

Classmates in school? ____________________

Playmates at home? ____________________

Did his/her father or anyone in father's family have a learning problem? .... Yes _____ No _____

Who? ____________________

Did his/her mother or anyone in mother's family have a learning problem?................ Yes _____ No _____

Who? ____________________

Do any other children in the family have learning problems? .... Yes _____ No _____

Who? ____________________

To what extent? ____________________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

PURPOSE OF EVALUATION? WHAT YOU HOPE TO LEARN FROM EVALUATION?:

I hereby give my permission to the San Diego Center for Vision Care – Optometry, P.C. to treat

______________________________________.
(Child's Name)

______________________________________ ______________________________
Parent or Guardian Signature Date

Would you be interested in online telemedicine consultations or conferences in the future?
Yes ____ No ____ Maybe ____

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to relate the current visual skills to any specific needs. Please be on time for your examination.

Thank you,
The Doctors and Staff
San Diego Center for Vision Care - Optometry, P.C.