



OPTOMETRY, P.C.

Carl G. Hillier, OD, FCOVD ♦ Melissa C. Hillier, OD, FCOVD ♦ Justin S. Matsuura, OD

VISION REHABILITATION QUESTIONNAIRE (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 _____

Business Address _____ City _____ Zip _____

Please Circle: Mother Father Both Other _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Occupation _____ Email Address _____

Business Address _____ City _____ Zip _____

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

What type of injury occurred?: _____

Date occurred: _____

Physician's name _____ Date of most recent visit _____

Results _____

Medications currently using _____

For what condition(s)? _____

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

	<u>Child</u>	<u>Family</u>		<u>Child</u>	<u>Family</u>
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Diabetes	_____	_____	Cataract	_____	_____
Thyroid Condition	_____	_____	Blindness	_____	_____
Multiple Sclerosis	_____	_____	Strabismus	_____	_____
Brain Tumor	_____	_____	Amblyopia	_____	_____
Stroke	_____	_____	Chromosomal Imbalance	_____	_____

Does your child have a history of food, drug or environmental allergies?..... Yes _____ No _____

If yes, please explain: _____

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

If yes, by whom? _____ Date _____

Results _____

Has a psychological evaluation been performed? Yes _____ No _____

If yes, by whom? _____ Date _____

Results _____

Has a speech and language evaluation been performed? Yes _____ No _____

If yes, by whom? _____ Date _____

Results _____

Has an occupational therapy evaluation been performed? Yes _____ No _____

If yes, by whom? _____ Date _____

Results _____

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

If yes, by whom? _____ Date _____

Results _____

Are there any other evaluations that have been performed?..... Yes _____ No _____

If yes, by whom? _____ Date _____

Results _____

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 performed? Yes _____ No _____

If yes, for how long? _____

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

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

Does your child experience any of the following?:	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
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	_____	_____	_____

HAVE YOU EVER NOTICED THE FOLLOWING?:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
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	_____	_____	_____
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: _____

NUTRITIONAL INFORMATION

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

Does your child:

like sweetsYes _____ No _____

crave sweetsYes _____ 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 _____

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 early speech clear to others? Yes _____ No _____ Is it clear now?Yes _____ No _____

“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) he/she 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.**