CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Linda Weil
Developmental Optometrist

CHILDREN'S SCHOOL AGE VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. THANK YOU.

GENERAL INFORMATION:

Child's Full Name____ Male _____ Female _____
Birth Date: ________________________________ Age: ______years ______months

Name and address of school: ____

Grade: _____ Teacher: ______________________________ School Nurse: ____________________

Social Worker: ____________________________________ Principal: ______________________

Reason for Visit: ____

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ______________________ Phone: __________________

Address: ______________________________________ Email Address: ____________________

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 ☐

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: ______________
Home Phone: ____________________________ Mother/Father Cell Phone: ______________________
Father/Caretaker's Occupation: ______________ Place of Employment: ______________________
Business Phone: ____________________________ Email Address: ______________________________
Mother/Caretaker's Occupation: ______________ Place of Employment: ______________________
Business Phone: ____________________________ Email Address: ______________________________

Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier?______________________ Policy #: ______________
Name of Insured:______________________________
Social Security Number: ______________________ Driver's License #: ____________________

MEDICAL HISTORY:
Pediatrician's Name: ______________________________ Phone Number: ___________________________
Pediatrician's Address: ____

Medications currently using, including vitamins and supplements:

1. _________________________ Condition: ___________________________
2. __________________________ Condition: ___________________________
3. __________________________ Condition: ___________________________
4. __________________________ Condition: ___________________________

List illnesses, bad falls, high fevers, etc.:

	Illness	Age	Severity (Mild-Severe)	Complications
1.				
2.				
3.				

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 ☐
If yes, by whom? ______________________________
Results and recommendations: ____

Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ____
Results and recommendations: ____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? ____
Results and recommendations: ____

Has a speech therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? ____
Results and recommendations:____

NUTRITIONAL INFORMATION:
Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
Is your child active (with respect to behavior and not sports)? Yes ☐ No ☐
If yes is he/she moderately or extremely active? ____

Medical History: Please mark an "X" on conditions that apply.

1. _____ Crossed Eyes.
2. _____ Amblyopic (lazy eye).
3. _____ Learning Disability.
4. _____ Dyslexia.
5. _____ ADD/ADHD.
6. _____ Asperger's Syndrome/Autism.
7. _____ Epilepsy/Seizure.
8. _____ Chromosomal Imbalance.
9. _____ Diabetes.
10. _____ High Blood Pressure.
11. _____ Glaucoma.
12. _____ Thyroid Condition.
13. _____ Multiple Sclerosis.
14. _____ Brain Tumor/Brain Injury
15. _____ Other. Please list:____
16. _____ Allergies to foods or medications. If yes, please list:_____________________________

Family History: Please mark an "X" on all conditions that apply and list the family member who has the following condition?

17. _____ Crossed Eyes. Family Member:____
18. _____ Amblyopic (lazy eye). Family Member: ______________________________________
19. _____ Learning Disability. Family Member: ______________________________________
20. _____ Dyslexia. Family Member: ____
21. _____ ADD/ADHD. Family Member: ____
22. _____ Asperger's Syndrome/Autism: Family Member :_____________________________
23. _____ Epilepsy/Seizure. Family Member: _______________________________________
24. _____ Chromosomal Imbalance. Family Member: _________________________________
25. _____ Diabetes. Family Member: ____
26. _____ High Blood Pressure. Family Member: ______________________________________
27. _____ Glaucoma. Family Member: ____
28. _____ Multiple Sclerosis. Family Member: ____
29. _____ Near-Sighted. Family Member: ____
30. _____ Far-Sighted. Family Member:____
31. _____ Other. Family Member:____

DEVELOPMENTAL HISTORY:

Was the pregnancy full term? Yes ☐ No ☐

Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, explain: ____

Did the mother smoke, drink alcohol, use legal or illegal drugs? Yes ☐ No ☐

If yes, explain:____

Was this a normal birth? Yes ☐ No ☐

Were there any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: ____

Birth weight: _______________ Apgar scores @ birth: ____________________ After 10 minutes: _______________

Were forceps used? Yes ☐ No ☐

Was there ever any reason for concern over your child's general growth or development?

If yes, explain: ____

Developmental Milestones: Please list the age your child was able to complete the following tasks:

Age: Task

________ Crawl on stomach on the floor.
________ Crawl on all fours.
________ Walk.
________ First words. Was speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐.
________ Undress and dress him/herself.
________ Manage snaps, zipper and buttons.
________ Tie shoes.

OCULAR 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 type? ____
Are they used? Yes ☐ No ☐ If yes, when? ____________________________
If not used, why not? _____________________________________

Does your child report any of the following?:

	Yes	No	If yes, when and how often?
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	☐	☐	______________

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	No	If yes, when and how often?
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	☐	☐	______________

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	Yes	No	If yes, when and how often?
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	☐	☐	______

	Yes	No	If yes, when and how often?
Difficulty recognizing same word on a 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 child watch TV? ____________ How much? ___________ How often? ___________ Viewing distance? ____________

Does your child spend time using computer/video games? Yes ☐ No ☐

If yes, how much time? ___________ How often? ________________ Viewing distance? ___________________________

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:

At what age did your child begin school: Pre-school:______ Kindergarten: ______ First Grade: ______________________

Does your child like school? Yes ☐ No ☐

Does your child like his teacher? Yes ☐ No ☐

Has your child changed schools often? Yes ☐ No ☐

If yes, when? ____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? ____

Is your child under tension or pressure when doing school work? Yes ☐ No ☐

If yes, please explain: ____

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 ☐

Does your child read voluntarily? Yes ☐ No ☐

Does your child read for pleasure? Yes ☐ No ☐

What? ____

Overall schoolwork is: above average ☐ average ☐ below average ☐

WHICH SUBJECTS 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 ☐

Specifically describe any school difficulties:

____

____

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? ____

How does your child react to fatigue? sad ☐ irritable ☐ other ☐

How does your child react 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 ☐ ☐ 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 to this situation? 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? ____________________

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?

Payment Policy/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.
- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature ____ **Date** _____________

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO EXCHANGE INFORMATION AND DISCUSS YOUR CHILD'S RESULTS WITH HIS/HER SCHOOL AND OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I give my consent to make copies of my child's record and share any pertinent data from this exam to the school and other professionals. I also give my consent to provide any information to the health care providers or insurance carriers upon their written request for processing my claims.
This authorization shall be considered valid throughout the duration of treatment.

_______________________________________ ___________
Signature Date

____
RELATIONSHIP TO PATIENT

Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your child's specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.

We request a minimum of 24 hours' notice if you are unable to keep this appointment.