CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

CHILDREN'S 0-3 YEARS VISION QUESTIONNAIRE

Child's Name: _____ Male _____ Female _____
Birth Date: _____ Age: _____years _____months
Reason for Visit: _____
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____ Email Address: _____
If not referred, how did you learn about our office? _____
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 #: _____

PATIENT'S MEDICAL HISTORY:

Pediatrician's Name: _____ Phone Number: _____
Medications currently using, including vitamins and supplements:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____

Allergies to foods or medications. If yes, please list: _____

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559

Tel: 630-323-7300
Fax: 630-323-7662

info@clarendonvision.com
clarendonvision.com

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

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

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 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: _____

Has your child been evaluated by any other medical specialist? Yes ☐ No ☐

If yes, by whom? _____

Results and recommendations: _____

PATIENT'S MEDICAL HISTORY: Please mark an "X" on conditions that apply.

_____ Strabismus (Crossed Eyes)
_____ Amblyopia (Poor Vision)
_____ Learning Disability
_____ Dyslexia
_____ ADD/ADHD
_____ Asperger's Syndrome/Autism
_____ Epilepsy/Seizure
_____ Chromosomal Imbalance
_____ Diabetes
_____ Thyroid Condition
_____ Brain Tumor/Brain Injury/Concussion
_____ Other, please list:_____

FAMILY MEDICAL HISTORY: Please mark an "X" on all conditions that apply and list the family member(s) who has the following condition?

_____ High Cholesterol - Family Member(s): _____
_____ Thyroid - Family Member(s): _____
_____ Heart Disease - Family Member(s): _____
_____ Cancer - Family Member(s): _____
_____ Diabetes - Family Member(s): _____
_____ High Blood Pressure - Family Member(s): _____
_____ Glaucoma - Family Member(s): _____
_____ Cataracts - Family Member(s): _____
_____ Macular Degeneration – Family Member(s): _____
_____ Retinal Detachment - Family Member(s): _____
_____ Strabismus (Crossed Eyes) - Family Member(s):_____

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_____ Amblyopia (Poor Vision) - Family Member(s): _____
_____ Near-Sighted - Family Member(s): _____
_____ Far-Sighted - Family Member(s):_____
_____ Other - Family Member(s): _____

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: _____
Were there any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____
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 ☐

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: _____

Wears glasses or other optical devices recommended? Yes ☐ No ☐
If yes, what type? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING IN YOUR CHILD:

	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	☐	☐	
Do eyes deviate or turn	☐	☐	
Does child squint	☐	☐	
Head close to paper when doing near tasks	☐	☐	
Dislikes/avoids near tasks	☐	☐	
Tilts head when doing near tasks (coloring, reading)	☐	☐	
Tilts head when doing distance tasks (TV, outside)	☐	☐	

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	Yes	No	If yes, when, and how often?
Will make eye contact	☐	☐	
Does child engage with pictures	☐	☐	
Difficulty following instructions	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Clumsy, tends to fall often	☐	☐	
Uncomfortable in new places	☐	☐	

GENERAL BEHAVIOR:

Are there any behavior problems (play groups, play dates)? 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 ☐

FAMILY AND HOME:

Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐

☐ Other Caretaker (please specify): _____

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 ☐

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?

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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 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.

THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, will be charged a $150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party _____ Date _____

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.

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