CLARENDON VISION DEVELOPMENT CENTER

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

CHILDREN'S PREREADER 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:

Father/Caretaker: _____ Birth Date: _____
Mother/Caretaker: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____

Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____
Social Worker: _____ Principal: _____

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: _____

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

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

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: _____

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): _____

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
Tel: 630-323-7300
Fax: 630-323-7662
info@clarendonvision.com
clarendonvision.com

_____ 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):_____
_____ 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, 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	☐	☐	
Double vision	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Motion sickness / car sickness	☐	☐	
Dizziness	☐	☐	

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
Tel: 630-323-7300
Fax: 630-323-7662
info@clarendonvision.com
clarendonvision.com

CLARENDON VISION DEVELOPMENT CENTER

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

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	☐	☐	
Difficulty seeing distant objects	☐	☐	
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)	☐	☐	
Will not make eye contact	☐	☐	
Confuses right and left	☐	☐	
Does not support/hold paper when writing	☐	☐	
Difficulty following instructions	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Awkward or immature pencil grip	☐	☐	
Cannot keep coloring or drawing on paper	☐	☐	
Cannot color within the lines	☐	☐	
Difficulty copying simple forms or letters	☐	☐	
Difficulty counting objects (stacked blocks)	☐	☐	
Difficulty with sensory tasks (Play-Doh, finger paint)	☐	☐	
Clumsy, tends to fall often	☐	☐	
Tires easily	☐	☐	
Remembers better what hears than sees	☐	☐	
Poor sequencing	☐	☐	
Short attention span / loses interest	☐	☐	
Poor balance	☐	☐	
Uncomfortable in new places	☐	☐	
Difficulty with scissors / small hand tools	☐	☐	
Dislikes / avoids sports	☐	☐	
Difficulty catching / hitting a ball	☐	☐	

ELECTRONIC USE/LEISURE TIME ACTIVITIES:

How much time does your child spend on electronics outside of school? Avg per day_____

How much time does your child spend outside? Avg per day_____

SCHOOL:

At what age did your child begin school: Pre-school:_____ Kindergarten: _____

Does your child like school? Yes ☐ No ☐

Does your child like their teacher? Yes ☐ No ☐

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559

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

info@clarendonvision.com
clarendonvision.com

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

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 like to be read to? Yes ☐ No ☐

Does your child follow along while reading together? Yes ☐ No ☐

Does your child engage with the pictures? Yes ☐ No ☐

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?

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
Tel: 630-323-7300
Fax: 630-323-7662
info@clarendonvision.com
clarendonvision.com

CLARENDON VISION DEVELOPMENT CENTER

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

RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. **The fee is $35.00.**

☐ I want my child to have the retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam for my child. I understand that a thorough eye exam with dilation will be performed.

Signature _____ Date _____

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.

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
Tel: 630-323-7300
Fax: 630-323-7662
info@clarendonvision.com
clarendonvision.com

- 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.

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559

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

info@clarendonvision.com
clarendonvision.com