CLARENDON
VISION
DEVELOPMENT
CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Linda Weil
Developmental Optometrist

CHILDREN'S PREREADER 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: ____

CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Linda Weil
Developmental Optometrist

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 doing near tasks	☐	☐	______
Dislikes/avoids near tasks	☐	☐	______
Tilts head when doing near tasks (coloring, reading)	☐	☐	______
Tilts head when doing distance tasks (TV, outside)	☐	☐	______
Confuses right and left	☐	☐	______
Does not support paper when writing	☐	☐	______

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

	Yes	No	If yes, when and how often?
Awkward or immature pencil grip	☐	☐	______
Cannot keep coloring or drawing on paper	☐	☐	______
Cannot color within the lines	☐	☐	______
Tires easily	☐	☐	______
Difficulty copying simple forms or letters	☐	☐	______
Difficulty counting objects (stacked blocks)	☐	☐	______
Difficulty with sensory tasks (Play-Doh, finger paint)	☐	☐	______

	Yes	No	If yes, when and how often?
Remembers better what hears than sees	☐	☐	______
Difficulty following instructions	☐	☐	______
Poor sequencing	☐	☐	______
Short attention span / loses interest	☐	☐	______
Poor large motor coordination	☐	☐	______
Poor balance	☐	☐	______
Poor fine motor coordination	☐	☐	______
Uncomfortable in new places	☐	☐	______
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: ______

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 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 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.

760 Pasquinelli Drive, Suite 300,
Westmont, IL 60559 USA

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

info@ClarendonVision.com
www.ClarendonVision.com