

## CHILDRENS 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:

<u>NAME</u>	<u>BIRTH DATE</u>
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 (laze eye).
3. \_\_\_\_\_ Learning Disability.
4. \_\_\_\_\_ Dyslexia.
5. \_\_\_\_\_ ADD/ADHD.
6. \_\_\_\_\_ Asberger'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 (laze eye). Family Member: \_\_\_\_\_
19. \_\_\_\_\_ Learning Disability. Family Member: \_\_\_\_\_
20. \_\_\_\_\_ Dyslexia. Family Member: \_\_\_\_\_
21. \_\_\_\_\_ ADD/ADHD. Family Member: \_\_\_\_\_
22. \_\_\_\_\_ Asberger'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:

- | <u>Age:</u> | <u>Task</u>   |
|-------------|---|
| _____       | 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?:

	<u>Yes</u>	<u>No</u>	<u>If yes, when and how often?</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision / focus goes in and out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____

**HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:**

	<u>Yes</u>	<u>No</u>	<u>If yes, when and how often?</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	_____

Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letter or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, rereads or omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awkward or immature pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent erasures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when and how often?</u>
Difficulty recognizing same word on a different page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remembers better what hears than sees	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responds better orally than by writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems to know material, but does poorly on tests	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span / loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with scissors / small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty catching / hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

**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:**

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? sag  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. 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.