



www.sandiegocenterforvisioncare.com

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Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

GENERAL INFORMATION

Were you referred? Yes _____ No _____

If yes, by whom? _____ Phone: _____

Address: _____

Child's Full Name: _____ Male _____ Female _____

Birth Date: _____ Age: _____ years _____ months

Name and address of school: _____

Grade _____ Teacher _____ School Nurse _____ Principal _____

Is your child especially afraid of doctors? Yes or No (please circle)

Child's handedness: Right or Left (please circle)

HOME: Father/Guardian _____ Birth Date _____

Mother/Guardian _____ Birth Date _____

Siblings _____ Birth Date _____

_____ Birth Date _____

_____ Birth Date _____

PARENT INFORMATION

Please Circle: Mother Father Both Other _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Business Address _____ City _____ Zip _____

Business Phone _____ Email Address _____

Please Circle: Mother Father Both Other _____

Home Address _____ City _____ Zip _____
 Home Phone _____ Cell Phone _____
 Business Address _____ City _____ Zip _____
 Business Phone _____ Email Address _____
 Do you have Major Medical Insurance? _____ Insured _____
 Social Security Number _____ Driver's License No. _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Results _____

Medications currently using _____

For what condition? _____

Any history in your family of the following:

Diabetes Yes _____ No _____

Glaucoma..... Yes _____ No _____

High blood pressure Yes _____ No _____

Macular Degeneration..... Yes _____ No _____

List illnesses, bad falls, high fevers, ear infections, head injuries, eye injuries, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child generally healthy? Yes _____ No _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes _____ No _____

If yes, please list _____

Has a speech / language evaluation been performed? Yes _____ No _____

By whom? _____ When? _____

Results _____

Has an occupational therapy evaluation been performed? Yes _____ No _____

By whom? _____ When? _____

Results _____

Has a neurological evaluation been performed? Yes _____ No _____

By whom? _____ When? _____

Results _____

Has a psychological evaluation been performed? Yes _____ No _____

By whom? _____ When? _____

Results _____

NUTRITIONAL INFORMATION

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____

Does your child:

like sweets Yes _____ No _____

crave sweets Yes _____ No _____

Is your child active? Yes _____ No _____

moderately? Yes _____ No _____

extremely? Yes _____ No _____

Are there periods of very high energy? Yes _____ No _____

very low energy? Yes _____ No _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes _____ No _____

Normal birth? Yes _____ No _____

Any complications before, during or immediately following delivery? Yes _____ No _____

Did your child crawl (stomach on floor)? Yes _____ No _____ At What Age? _____

Did your child creep (stomach off floor)? Yes _____ No _____ At What Age? _____

All fours? Yes _____ No _____

If not, describe _____

At what age did your child walk? _____ Was your child active? Yes _____ No _____

Speech: First words at age _____

Was early speech clear to others? Yes _____ No _____ Is it clear now? Yes _____ No _____

VISUAL HISTORY

Doctor's Name _____ Date of Last Visit _____

Reason for examination: _____

Results _____

Were glasses prescribed? Yes _____ No _____ Are they worn? Yes _____ No _____

If yes, when are they worn? _____

Was Vision Therapy prescribed Yes _____ No _____

Was Vision Therapy done? Yes _____ No _____

If yes, for how long? _____

Members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Is there any evidence from the school, psychological, pediatric, occupational therapy, or speech/language tests that indicate some visual malfunction may be present? Yes _____ No _____

If yes, what? _____

Does your child report any of the following:	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	_____	_____	_____
Blurred vision	_____	_____	_____
Double vision	_____	_____	_____
Eyes "hurt" or tired	_____	_____	_____
Words move around on the page	_____	_____	_____
Motion sickness	_____	_____	_____

List any other complaints your child makes concerning his/her vision:

HAVE YOU EVER NOTICED THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes frequently reddened	_____	_____	_____
Frequent eye rubbing	_____	_____	_____
Frequent blinking	_____	_____	_____
Closing or covering one eye	_____	_____	_____
Head close to paper when reading or writing	_____	_____	_____
Tilting head when reading or writing	_____	_____	_____
Moving head when reading	_____	_____	_____
Confusing letters or words (circle one or both)	_____	_____	_____
Reversing letters or words (circle one or both)	_____	_____	_____
Skipping, rereading and omitting words	_____	_____	_____
Losing place while reading	_____	_____	_____
Vocalizing when reading silently	_____	_____	_____
Reading slowly	_____	_____	_____
Using finger as a marker	_____	_____	_____
Poor reading comprehension	_____	_____	_____
Poor spelling	_____	_____	_____
Writing or printing poorly	_____	_____	_____
Tiring easily	_____	_____	_____
Difficulty completing assignments	_____	_____	_____
Avoids activities that are within arms reach	_____	_____	_____
Shortened attention span for reading or writing	_____	_____	_____
Poor motor coordination	_____	_____	_____
Difficulty catching or hitting a ball	_____	_____	_____

Difficulty copying from the board at school _____

“SCREEN TIME”

Academic Computer time: Days per week _____ Hours per day _____ Distance from eyes to screen _____
Computer/TV Video Games: Days per week _____ Hours per day _____ Distance from eyes to screen _____
Hand held video games: Days per week _____ Hours per day _____ Distance from eyes to screen _____
Television: Days per week _____ Hours per day _____ Distance from eyes to screen _____
Texting: Days per week _____ Hours per day _____ Distance from eyes to screen _____

SCHOOL

Age at time of entrance to: Kindergarten _____ First Grade _____

Does your child like school?.....Yes _____ No _____

Has your child changed schools often?.....Yes _____ No _____

If yes, when? _____

Has a grade been repeated?.....Yes _____ No _____

If yes, which? _____

Does your child seem to be under tension or extreme pressure when doing schoolwork?. Yes _____ No _____

Does your child avoid homework?..... Yes _____ No _____

Does your child take too long to do homework? Yes _____ No _____

Has your child had any special tutoring and/or remedial assistance?..... Yes _____ No _____

If yes, when? _____

From whom? _____

Where? _____

How long? _____

Result: _____

What school subjects are easy for your child? _____

What school subjects are difficult for your child? _____

Does your child like to read? Yes _____ No _____ Does your child like to be read to? Yes _____ No _____

Voluntarily? Yes _____ No _____ What? _____

Specifically describe any school difficulties: _____

What is your child’s attitude toward reading, school, his/her teachers, other youngsters? _____

Does your child have an I.E.P.? Yes _____ No _____ A 504 Plan? Yes _____ No _____

An Advocate? Yes _____ No _____ Who? _____

School work is: Above average _____ Average _____ Below average _____

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 _____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes _____ No _____

Are there any behavior problems at home? Yes _____ No _____

What causes these problems? _____

Your child's reaction to fatigue? sag _____ irritable _____ other _____

Your child's reaction to tension? nail-biting _____ thumb-sucking _____ 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 _____ Foster Parents _____

Adoptive Parents _____ Grandmother _____ Grandfather _____ Aunt _____ Uncle _____

Other _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes _____ No _____

What age was (s)he? _____

Does your child seem to have adjusted? Yes _____ No _____

Is family life stable at this time? Yes _____ No _____

How does your child get along with:

Parents? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did his/her father or anyone in father's family have a learning problem? Yes _____ No _____

Who? _____

Did his/her mother or anyone in mother's family have a learning problem? Yes _____ No _____

Who? _____

Do any other children in the family have learning problems? Yes _____ No _____

Who? _____

To what extent? _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

