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OPTIQUE EYECARE
Focused On Your Ocular Health

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Date: _____

General Information

Name: _____ Sex:_____ Phone: _____
Address:_____ City: _____State:_____ Zip: _____
Date of Birth:_____ Age: _____ Years: _____ Months: _____ Adopted: _____When: _____
School:_____ Address: _____ Grade: _____ Teacher_____
Father's Name: _____ Occupation: _____ DOB:_____ Business Phone:_____
Living with Child _____ Deceased:_____ Divorced: _____
Mother's Name: _____ Occupation: _____ DOB:_____ Business Phone:_____
Living with Child _____ Deceased:_____ Divorced: _____
Nature of difficulty:_____
_____
_____
Referred by:_____Address: _____

Family History

Siblings:

Name: _____Date of Birth:_____
Name: _____Date of Birth:_____
Name: _____Date of Birth:_____
Name: _____Date of Birth:_____
Name: _____Date of Birth:_____

Relatives or other parties living in the home:

Name: _____Relation: _____
Name: _____Relation: _____
Name: _____Relation: _____

Developmental History

Prenatal History:

Health of mother during pregnancy: _____
_____ Medications: _____

Birth History:

Was child: Full term? _____ Premature? _____ If premature, how many weeks? _____
Was Labor: Difficult? _____ Easy? _____ Length of labor: _____
Did your baby come home with you after birth? _____ If not, why? _____

Postnatal (please give exact age when possible):

Sat up alone:_____ Crawled:_____ How: _____Walked alone:_____

Speech and language development (give exact age where possible):

First word/words: _____ First short sentence: _____
Does the child have trouble talking? _____ If so, describe? _____

Health History

Following is a list of diseases, where possible, please note age and seriousness

Scarlet Fever: _____ Rheumatic Fever: _____
Whooping Cough: _____ Diphtheria: _____
Measles: _____ Chicken Pox: _____
High Fevers: _____ Pneumonia: _____
Croup: _____ Mumps: _____
Seizures/Convulsions: _____
Has your child ever been hospitalized? _____ If so, why & when? _____
_____

General Health

Does the child have a hearing loss? _____ If yes, describe: _____

_____

_____

Most recent medical exam: Date: _____ Doctor: _____

Key Results: _____

Presently under physician's care: _____ If yes, for what? _____

_____

Medications currently using: _____

Medications are for what condition(s)? _____

Any family history of:

❑ Diabetes ❑ High Blood Pressure ❑ Other: _____

Is the child generally healthy? _____

Are there any chronic problems like asthma, hay fever and/or allergies? _____ If so, please list: _____

_____

Has a neurological evaluation been performed? _____ By whom? _____

Results: _____

Has a psychological evaluation been performed? _____ By whom? _____

Results: _____

Current Diet: Excellent: _____ Good: _____ Fair: _____

Does child crave sweets? _____ If so, how much? _____

Is your child active? _____ If so, how much? _____ Moderately? _____ Extremely? _____

Are there periods of very high energy? _____ Low energy? _____

Visual History

Presently wearing glasses/contacts? _____ Does he/she cover one eye while reading? _____
Does he/she have headaches often? _____ When?

Does he/she complain of words moving on a printed page?_ _____
Does he/she complain of seeing two things when there is only one?_____
Do his/her eyes ever:

❑ Twitch ❑ Itch ❑ Burn ❑ Water ❑ Blur ❑ "Hurt"/" Tire"

Has he/she ever had any injuries to his eye or head? _____
Is he/she right or left-handed?_____ Has handedness ever changed? _____
Handicaps? _____ If yes, please describe:_____
_____
List any other complaints your child has made concerning his/her vision: _____
_____
_____

Have you ever noticed the following?

Condition	Yes	No	If so, when?
Eyes frequently reddened	❑	❑	_____
Frequent eye rubbing	❑	❑	_____
Frequent blinking	❑	❑	_____
Closing or covering one eye	❑	❑	_____
Head close to paper when reading/writing	❑	❑	_____
Tilting head when reading	❑	❑	_____
Tilting head when writing	❑	❑	_____
Moves head when reading	❑	❑	_____
Confuses letters/words	❑	❑	_____
Reverses letters/words	❑	❑	_____
Skips, rereads and/or omits words	❑	❑	_____
Vocalizes when reading silently	❑	❑	_____
Reads slowly	❑	❑	_____
Uses finger as marker	❑	❑	_____
Poor reading comprehension	❑	❑	_____
Writes or prints poorly	❑	❑	_____
Tires easily	❑	❑	_____
Avoids near tasks	❑	❑	_____
Short attention span	❑	❑	_____
Poor motor coordination	❑	❑	_____
Difficulty catching/hitting a ball	❑	❑	_____

Television viewing

How much? _____ How often?_____ Viewing distance? _____

School

Age when started kindergarten: _____ First grade:_____

Does the child like School?_____ Teachers?_____

School Work is: ❑ Above Average ❑ Average ❑ Below Average

Do you feel he/she is working up to potential?_____

Do teachers feel he/she is working up to potential?_____

What school subjects are easy for the child?_____

What school subjects are difficult for the child? _____

Does the child like to read? ___ Voluntarily?_____ Types of books? _____

Specifically describe any school difficulties: _____

_____

When was difficulty notice?_____

Has child received special education services? _____If yes, what services? _____

_____

Has a grade(s) been repeated? _____If yes, which grade(s)? _____

Has he/she changed schools often?_____If yes, when was last change?_____

Does he/she seem to be under tension or extreme pressure when doing schoolwork? _____

Has he/she had any special tutoring and/or remedial assistance? _____

When? _____ From whom?_____ Where? _____

How long? _____ Results? _____

What is child's attitude toward reading, school, his/her teaches or other youngsters?_____

How well developed is your child's spoken vocabulary?_____

General Behavior

Are there any behavior problems at school?_____ Home? _____

What causes the problems?_____

Child's reaction to fatigue: ❑ Sag ❑ Irritable ❑ Other:_____

Child's reaction to tension: ❑ Nail biting ❑ Thumb sucking ❑ Other:_____

Does he/she say and/or do things impulsively? _____ In constant motion?_____

Cannot sit still for long periods? _____

Does the child wet the bed? _____ If yes, under what conditions?_____

_____

Check the words that apply to your child most often:

❑ Calm	❑ Cooperative	❑ Hyperactive	❑ Alert	❑ Affectionate
❑ Excitable	❑ Moody	❑ Very Outgoing	❑ Withdrawn	❑ Cheerful
❑ Stubborn	❑ Stays to self	❑ Easily corrected	❑ Difficult to manage	❑ Lazy
❑ Gets along with other children		❑ Accepts supervision from adults		

Do you feel the child may be having some emotional problems as results of death, trauma, abuse, separation divorce?

_____

_____

_____

Give any additional comments:

_____
_____
_____

Family and Home

Describe how he/she get along with:

Parents? _____
Siblings? _____
Classmates in school? _____
Playmates at home?_____
Did father or anyone in father's family have a learning problem? _____
Who? _____
Did mother or anyone in mother's family have a learning problem? _____
Who? _____
Is there any history of mental disability, psychological disturbance, etc., on either side of the family? _____
_____
Do any, or did any, of the other children in the family have learning problems?_____
Who? _____ To what extent?_____
_____

Give a Brief Description of Your Child as a Person

_____

_____

_____

_____

Thank you for carefully completing this questionnaire. The information supplied will allow for more efficient use of time. It will permit us to make a complete optometric evaluation of your child's visual system related to his/her specific needs.

Thank you,

Dr. Adams and the Vision Therapy staff at Optique EyeCare

30 Question Predictive Checklist

Please consider each question and circle the number that best applies to the patient.

Name: _____Date: _____ Age:_____

	Never	Seldom	Occasional	Frequent	Always	Score
Blur when looking at near	**0**	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itchy or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying form the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Write up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is "I can't" before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motions sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	

20-24 points suspect 25 points or higher refer for care Total Score:

Insurance Information

To provide you the best service and assure the timely processing of your insurance claims, please provide your insurance information.

Insurance Name: _____

Insurance ID Number: _____

Name of Policy Holder: _____

Policy Holders Date of Birth: _____

Policy Holders Social Security Number: _____

Financial Responsibility Statement

Your insurance is a method for you to pay for products and services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your plan. You are usually responsible for any charges above these amounts. It is your responsibility to pay in advance for the deductibles and co-insurance fees. We will assist you in recovering reimbursement for your remaining balance as much as possible but you are responsible for the full balance.

You or the guarantor are ultimately responsible for all charges for products and services rendered in our office. There are no exceptions.

If any outstanding balance remains after 90 days, we reserve the right to use an outside collection agency to assist in the recovery of the delinquent account. All associated fees will be charged to the patient or guarantor of the account.

HIPAA Receipt

By signing below, you acknowledge that you have been offered a copy of the office's Notice of Privacy Practices.

By signing this statement you agree to all terms shown on both sides.

Patient or Guarantor E-Mail: _____

Patient or Guarantor Signature: _____ Date: _____

Patient's Name (Print): _____