Wolman Vision and Therapy Center
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Harrison, NY 10528
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Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day, 7 days a week. We request a minimum of 24 hours notice if you are unable to keep your appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

Thank You,

Stephanie L. Wolman, OD, FCOVD
Developmental Optometrist

CHILDREN'S VISION QUESTIONNAIRE

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

GENERAL INFORMATION

How did you hear about our office? _____

Child's Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Grade: _____ School: _____ Teacher: _____

Mother's Name: _____ Mother's Cell Phone: _____

Mother's E-mail: _____ Mother's Work Phone: _____

Father's Name: _____ Father's Cell Phone: _____

Father's E-mail: _____ Father's Work Phone: _____

Vision Insurance: Plan name: _____ ID#: _____

Policy holder name: _____ Relationship to policy holder: _____

Policy holder date of birth: _____ Policy holder social security number:_____

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes No Date: _____

Doctor's name: _____ Results/Recommendations: _____

Were glasses, contact lenses, or other optical devices recommended? Yes No

If yes, for what? _____

Are they used? Yes No If yes, when? _____ If no, why not? _____

Any visual issues in the family? _____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed? _____

Is there any evidence from school, psychological, or other tests that indicate a visual problem is present? Yes No

If yes, explain: _____

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? _____

MEDICAL HISTORY

Pediatrician's Name/Address: _____

Medications currently using, including supplements: _____

Allergies to medication or food: _____

Past or present chronic problems/diagnosis' such as ear infections, asthma, hay fever, ADHD? Yes No

If yes, please list: _____

Has a neurological evaluation been performed? Yes No

By whom? _____ Results/Recommendations: _____

Has a psychological evaluation been performed? Yes No

By whom? _____ Results/Recommendations: _____

Has an occupational therapy evaluation been performed? Yes No

By whom? _____ Results/Recommendations: _____

Has a speech therapy evaluation been performed? Yes No

By whom? _____ Results/Recommendations: _____

Has a physical therapy evaluation been performed? Yes No

By whom? _____ Results/Recommendations: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

Did mother experience any health problems during the pregnancy? Yes No

If yes, explain: _____

Any complications before, during, or after birth? Yes No

If yes, explain: _____

Birth weight: _____ Age child crawled: _____ Age child walked: _____ Age child talked: _____

SCHOOL HISTORY

Age at time of entrance to: Pre-School: _____ Kindergarten: _____ First Grade: _____

Does your child like school? Yes No

Does your child like to read? Yes No

Has a grade been repeated? Yes No If so, which grade? _____

Specifically describe any school difficulties: _____

_____

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes No

If yes, what and when? _____

Overall school work is: above average average below average

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes No

Please check off any signs/symptoms that your child experiences:

_____ Skips words or lines of text while reading
_____ Re-reads words or skips lines of text
_____ Reads slowly
_____ Uses finger or other device to keep place while reading
_____ Complains of blur while reading, writing, or using a computer
_____ Complains that words or lines of text “run together” or “jump around”
_____ Complains of seeing double
_____ Experiences motion sickness

_____ Fatigues after maintaining visual concentration for a short time
_____ Holds reading material close to face
_____ Improper or awkward posture while reading
_____ Moves head while reading
_____ Covers or closes one eye
_____ Avoids close work
_____ Tilts head to one side

_____ One eye turns in or out, up or down
_____ Excessive squinting from bright light
_____ Rubs eyes frequently
_____ Blinks excessively
_____ Frowns, scowls, or squints
_____ Excessive tearing of the eyes
_____ Reddened eyes or lids
_____ Headaches

_____ Short attention span
_____ Poor recall of visually presented information
_____ Difficulty visualizing what he/she reads
_____ Whispers to self or moves lips while reading
_____ Comprehends better if someone reads to him/her rather than reading on own

_____ Clumsy, bumps into things
_____ Lack of coordination and balance
_____ Difficulty sitting still
_____ Poor athletic performance

_____ Repeatedly confuses right and left
_____ Reverses letters, numbers, or words
_____ Reads or writes backwards

_____ Mistakes words with same or similar beginnings and endings
_____ Difficulty with alphabet recognition
_____ Fails to recognize the same word in the next sentence or on the next page
_____ Confuses likenesses and minor differences
_____ Poor spelling skills
_____ Poor math skills

_____ Difficulty completing work
_____ Works slowly compared to peers
_____ Difficulty discriminating relevant from irrelevant
_____ Ignores details of visual tasks
_____ Poor comprehension during visual tasks

_____ Poor eye-hand coordination
_____ Sloppy handwriting
_____ Difficulty writing on a line and or spacing words
_____ Difficulty copying from a book or the board to a notebook
_____ Can respond orally but has difficulty producing answers on paper
_____ Difficulty completing written work in the time allotted

RELEASE OF INFORMATION AND INSURANCE FILING:

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of Dr. Stephanie L. Wolman when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Wolman to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

Relationship to Patient

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given by you, your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the tight to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: _____