LAS VEGAS CENTER FOR VISION THERAPY
Vision Development & Rehabilitation

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Children's Vision Rehabilitation Questionnaire

Please fill out this questionnaire carefully, and if possible, return it to our office prior to the appointment. Thank you.

General Information

Patient's Name: ____

Birth Date: ____/____/________ Age: ____ *years* ____ *months* Gender: ☐ Male ☐ Female

Name of School: ____

Grade: _______ Teacher: ______________________ School Nurse: ______________________

Special Ed Teacher: ______________________ School Occupational Therapist: ______________________

Home Address: ______________________ City: ____________ State: ________ Zip: __________

Home Phone: (_________) ____________________

Parent/Guardian's Name: ______________________________

Business Phone: (_________) ____________________ Cell Phone: (_________) ____________________

Occupation: ______________________ Email: ______________________

Parent/Guardian's Name: ______________________________

Business Phone: (_________) ____________________ Cell Phone: (_________) ____________________

Occupation: ______________________ Email: ______________________

Sibling Name: ______________________ Age: ________

Sibling Name: ______________________ Age: ________

Sibling Name: ______________________ Age: ________

Sibling Name: ______________________ Age: ________

Were you referred to our office? ☐ Yes ☐ No

If yes, whom may we thank for referring you to our office? ______________________

Address: ______________________ Phone Number: (_______) _______ - __________

Medical History

Date of Injury: ____/____/________

Type of Injury: ☐ Motor Vehicle Incident ☐ Fall ☐ Blow to Head ☐ Sports-related Accident ☐ Medication-Related ☐ Drug Overdose

☐ Poison/Toxic Substance Exposure ☐ Carbon Monoxide Exposure ☐ Drowning ☐ Stroke

☐ Other: ______________________

Which part of your child's head was affected *(check all that apply)*?

☐ Forehead ☐ Right Side ☐ Left Side ☐ Back of Head ☐ Top of Head ☐ Face

Was the injury… ☐ *OPEN (with external bleeding)* ☐ *CLOSED (with no external bleeding)*

Did your child lose consciousness? ☐ Yes ☐ No; If yes, for approximately how long? ________________

Was your child in a coma? ☐ Yes ☐ No; If yes, for approximately how long? ________________

Symptoms immediately following the injury *(check all that apply)*:

☐ Double Vision ☐ Headache ☐ Blurred Vision ☐ Pain in or around the eyes ☐ Dizziness ☐ Vomiting ☐ Flashes or Light

☐ Disorientation ☐ Loss of Balance ☐ Neck Pain ☐ Loss of Memory ☐ Other: ______________________

Initial Treatment

On what date did you first see a doctor regarding your child's injury? ____/____/________

Physician's Name: ______________________________ Specialty: ______________________

Where were you seen? ____

Was your child hospitalized? ☐ Yes ☐ No; If yes, for approximately how long? ______________

What initial treatments did your child receive? ____

What were you told? ____

What prognosis and/or recommendations were you given? ________________________________

____

Was your child given medications? ☐ Yes ☐ No; If yes, what medications? ______________________

For what condition(s)? ____

Subsequent Treatment

Current Pediatrician's Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

Has your child received (or is your child currently receiving) treatment from any of the following health care professionals *(check all that apply)*:

☐ Physiatrist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Neurologist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Neuropsychologist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Physical Therapist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Speech Therapist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Psychologist– Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Psychiatrist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ____

____

☐ Osteopathic Physician – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ______________________________

____

☐ Occupational Therapist – Name: ______________________________ Date of Last Visit: ____/____/________

Results & Recommendations: ______________________________

____

Medications currently using, including vitamins and supplements: ______________________________

____

For what condition(s)? ______________________________

____

Is your child allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list: ______________________________

List any other prior major illnesses or injuries: ______________________________

____

Is there any history of the following *(please check all that apply)*?

	Patient	Family	Relationship		Patient	Family	Relationship
Diabetes	☐	☐	________	High Blood Pressure	☐	☐	________
Glaucoma	☐	☐	________	Cataracts	☐	☐	________
Blindness	☐	☐	________	Thyroid Condition	☐	☐	________
Multiple Sclerosis	☐	☐	________	Strabismus	☐	☐	________
Brain Tumor	☐	☐	________	Amblyopia	☐	☐	________
Stroke	☐	☐	________	Traumatic Brain Injury	☐	☐	________

Visual History

Has your child's vision been previously evaluated? ☐ Yes ☐ No

If yes, doctor's name: ______________________________ Date of last exam: ____/____/________

Reason for exam: ______________________________

Results/Recommendations: ______________________________

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

If yes, what was recommended? ______________________________

Are they used? ☐ Yes ☐ No If yes, when? ______________________________

If not used, why? ______________________________

____

____

Check the column that currently best represents the occurrence of each symptom.

	Never	Seldom	Occasionally	Frequently	Always
Blurry vision when looking at near objects					
Double vision					
Headaches with near work *(reading, computer use, etc.)*					
Words run together or move when reading					
Burning, itchy, or watery eyes					
Falls asleep while reading					
Vision worse at the end of the day					
Skips/repeats lines when reading					
Dizziness/nausea with near work					
Head tilt/closing one eye when reading					
Difficulty copying from chalk/whiteboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill or downhill					
Misaligns digits/columns of numbers					
Reading comprehension decreased/poor					
Holds reading objects too close					
Trouble maintaining attention with reading					
Difficulty completing assignments on time					
Poor hand/eye coordination and/or poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Eyes Ache					
Difficulty Moving or Turning Eyes					
Pain In or Around Eyes					
Eye Redness					
Sensitivity to Brightness/Light					
Difficulty Changing Focus from Far to Near					
One Eye Turns In, Out, Up, or Down					

Why do you feel your child needs a visual evaluation today? ______________________________

____

____

____

____

Parent/Guardian Preference Regarding Communication with Our Office

It is often beneficial for us to discuss examination results and to exchange information with ***your child's school, pediatrician, and/or other professionals*** involved in his/her care. Please provide the information and sign below to authorize this exchange of information.

I hereby give my permission for information from, or copies of, the examination records of my child, ________________________________, to be forwarded to other health care providers when it is necessary for the treatment of my child's visual condition. I further authorize representatives of the Las Vegas Center for Vision Therapy to exchange information with my child's school and other professionals involved in my child's care. The professionals are listed below. This authorization shall be valid for the duration of treatment or until a written request to the contrary is received.

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

In addition, if you prefer, we may discuss examination results and exchange information with ***your child's family member(s) and/or friend(s)*** who are involved in his/her care. Please provide the information and sign below to authorize this exchange of information.

I hereby give permission to the Las Vegas Center for Vision Therapy to disclose and discuss any information related to my child's visual and medical condition(s) with the following family member(s) and/or friend(s):

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

How should we contact you?

□ Home phone □ Work phone □ Cell phone □ Cell phone Text

If we cannot reach you by telephone,

□ Leave a message with details, including health information

□ Leave a message with call back number only

If you provide your email address, we may contact you via email for appointment reminders, sending reports, and general correspondence. Emails are sent from our secure system; we will not send health information if you request us to do so.

The information provided on this questionnaire is current and correct to the best of my knowledge, and I hereby give my permission to the doctors and therapists at Las Vegas Center for Vision Therapy to treat my child.

____ _________________ ______/______/____________

Signature of patient (or parent/legal representative) *Relationship to patient* *Date*

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 on our secure voicemail or email. We request a minimum of 24 hours notice if you are unable to keep this appointment. Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.