LAS VEGAS CENTER FOR VISION THERAPY
Vision Development & Rehabilitation

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Children's Vision Questionnaire – Optometrist Referral

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: _____

Whom may we thank for referring you to our office? _____

Address: _____ Phone Number: (_____) _____ - _____

Medical History

Pediatrician's Name: _____ Date of Last Visit: ____/____/_____

For what reason? _____

Results & Recommendations: _____

_____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

_____

List major illnesses or injuries and age of occurrence: _____

_____

_____

Does/did your child have chronic ear infections: ☐ Yes ☐ No Asthma? ☐ Yes ☐ No

Hay fever/environmental allergies? ☐ Yes ☐ No Food allergies? ☐ Yes ☐ No

Please list specific allergies: _____

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

	Patient	Family	Relationship		Patient	Family	Relationship
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye *(Eye Turn/Strabismus)*	☐	☐	_____	Learning Disability	☐	☐	_____
"Lazy" eye *(Amblyopia)*	☐	☐	_____	Chromosomal Disorder	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Glaucoma	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____	Other	☐	☐	_____

If other, please explain: _____

Developmental History

Full-term pregnancy? ☐ Yes ☐ No If no, how many weeks? _____

Did your child crawl (stomach on the floor)? ☐ Yes ☐ No At what age? _____ *months*

Did your child creep (on all fours, stomach off the floor)? ☐ Yes ☐ No At what age? _____ *months*

If not, please describe: _____

At what age did your child walk? _____ *months*

Speech: First words: _____ At what age? _____ *months*

Was the early speech clear to others? ☐ Yes ☐ No Is speech clear now? ☐ Yes ☐ No

Visual history

Date of last eye 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? _____

Please list any immediate family members who have had vision treatment, including reason for therapy: _____

Present Situation

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

_____

_____

_____

_____

_____

How long has the problem/difficulty been observed? _____

Is there any evidence from school, psychological, or other testing that indicates some visual problem may be present? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

_____

_____

Check the column that 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					
Poor/inconsistent in sports					
Poor hand/eye coordination and/or poor handwriting					
Clumsy, knocks things over					
Car/motion sickness					
Eyes Hurting					
Eyes Tired					
Eyes frequently reddened					
Frequent eye rubbing					
Eyes frequently reddened					
Confusing of letters/words					
Reversal or letters/words					
Difficulty recognizing the same word on different page					
Difficulty with memory					
Better memory with hearing versus seeing					

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: Primary Care Optometrist

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: _____

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.