

LONG ISLAND OPTOMETRIC VISION DEVELOPMENT, PLLC

DEVELOPMENTAL OPTOMETRISTS

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Developmental Vision Evaluation Child History Form

Patient's First Name: _____ Patient's Last Name: _____
Patient's Nickname: _____ Date of Birth: _____ Age: _____
Home Address: _____ City: _____ Zip: _____
Home Telephone: _____ Social Security# _____
School Name: _____ School Address: _____
Current Grade: _____ Type of Classroom: () Regular Education () Special Education () Other: _____

Father's First Name: _____ Father's Last Name: _____
Father's Telephone: Home: () _____ Cell: () _____ Work: _____
Father's Occupation: _____ Email Address: _____ @ _____
Mother's First Name: _____ Mother's Last Name: _____
Mother's Telephone: Home: () _____ Cell: () _____ Work: _____
Mother's Occupation: _____ Email Address _____ @ _____
Names and ages of siblings:

Who may we thank for referring you? _____ Profession: _____
Address: _____ Phone: _____

ACCOUNT RESPONSIBLE INFORMATION

Person responsible for payment: Mother () Father () Other () _____

Do You Have **Major Medical** Insurance? Yes () No () Company: _____
Insurance Address: _____ Insurance Phone: _____
Subscriber Name: _____ DOB: _____ SSN: _____
Subscriber ID#: _____ Group#: _____

Do You Have A **Vision** Insurance Plan? Yes () No () Company: _____
Insurance Address: _____ Insurance Phone: _____
Subscriber Name: _____ DOB: _____ SSN: _____
Subscriber ID#: _____ Group #: _____

PLEASE REMEMBER TO BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT.

Please read and sign the statement below:

I understand that payment is expected when services are rendered.

I will be paying today by: cash _____ check _____ credit card _____

Signature: _____ Date: _____

If minor, responsible party

VISION HISTORY

Last Vision Examination Date: _____ Name of Doctor/Address: _____

Were Glasses Prescribed? () No () Yes, To Be Worn: _____

Other Recommendations Given: _____

What is the main reason for bringing your child for a developmental vision evaluation? _____

Has any other professional evaluation found evidence indicating a vision dysfunction is present? () Y () N

If Yes, what? (ie: school evaluation, psychological evaluation, vision exam) _____

Does your child report any of the following?	No	Yes	If yes, when?
Blurred distance vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyestrain or visual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensitivity to sunlight or bright lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Words split or move on the page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Car sickness/Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you or others notice any of the following with your child?	No	Yes	If yes, when?
Covers or closes one eye when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place along lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye appears to turn inward/outward	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads very slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequently blinks or rubs eyes with near work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Makes errors or is slow in copying from the chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sustaining attention when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty understanding reading material	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brings near work very close to eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters/numbers (ie: b/d, S/5)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Translates numbers (152/512)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty retaining sight words previously learned	<input type="checkbox"/>	<input type="checkbox"/>	_____
Very verbal and knowledgeable, yet does poorly on tests	<input type="checkbox"/>	<input type="checkbox"/>	_____
Performs poorly on standardized testing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poorly organized handwriting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clumsy, bumps into things often in environment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor eye-hand coordination in sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequently erases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor spelling skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequently says "I Can't" before trying a task	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child ever had:	No	Yes	When/with whom?
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye patching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL HEALTH HISTORY

Is your child generally healthy? () Yes () No, please explain: _____

Has your child ever had any bad falls, concussions, significant illness, high fevers or seizures of any sort in the past? If yes, please describe: _____

Does your child have/take any of the following?

	No	Yes	Please describe below
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vitamins/supplements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies to medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies to foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/depression/fears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional concerns in the family	<input type="checkbox"/>	<input type="checkbox"/>	_____

Pediatrician's Name: _____ Date of Last Visit: _____
 Address: _____ Phone: _____

Has your child ever been evaluated by the following professionals?

Neurologist () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Psychologist () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Occupational Therapist () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Speech Therapist () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Audiologist () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Other: _____ () Yes () No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Has your child or a family member ever been treated for any condition relating to:

	Patient	Family	Whom?		Patient	Family	Whom?
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Does your child or family member have any of the following?

	Patient	Family	Whom?		Patient	Family	Whom?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macula Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed or wall eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genetic Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	_____

DEVELOPMENTAL HISTORY

Full-term Pregnancy? Yes No

Any complications during pregnancy or delivery? No Yes _____

Any complications immediately after birth? No Yes _____

Birth Weight: _____ Apgar Scores: _____

At what age did your child achieve the following milestones: Rolling Over: _____ Sitting Up _____

Crawl: _____ Walk: _____ Verbalize Sounds: _____ Verbalize Words: _____

Has your child had early intervention services? No Yes Please describe: _____

EDUCATIONAL HISTORY

Does your child enjoy school? Yes No

Does the teacher express any particular concerns with how your child is progressing in school? No Yes

Please describe: _____

What services is your child currently receiving **in school**? Please check all that apply:

Occupational Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Physical Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Speech Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
ABA Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Reading Support:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Math Support:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Other: Please describe: _____					

What services is your child currently receiving privately **outside of school**? Please check all that apply:

Occupational Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Physical Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Speech Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
ABA Therapy:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Reading Support:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Math Support:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No. times per week: _____
Other: Please describe: _____					

Please check all behaviors that apply to your child:

- Homework takes an extraordinarily long time for my child to complete
- Procrastinates with starting schoolwork and homework
- Not independent with homework; I must sit with my child in order for him/her to complete it
- Does not enjoy reading for pleasure
- Enjoys being read to by parent, but will not do on his/her own
- Class clown
- Appears unmotivated and lazy with academic tasks
- Has low self-esteem and thinks s/he is stupid
- Frequently says "I can't" when asked to do reading, writing or other academic tasks
- Is highly verbal and has a lot of knowledge, yet is not achieving in the classroom

Is there anything else you would like to share that concerns you about your child?

FINANCIAL POLICY:

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide you with a receipt for reimbursement submission. Any copayments are required at the time of service.

We are participating providers with: Blue Cross Blue Shield, Aetna US Healthcare and Medicare. By signing below you authorize the release of any medical information to process your insurance claims. You also allow your payment from insurance to be sent directly to Long Island Optometric Vision Development, PLLC.

Please sign that you understand the above:

Signed: _____ Date: _____

Quality of Life Symptom Checklist-Child

Today's Date: _____

Person Filling out form: _____

Patient Name: _____

Date of Birth: __/__/__

Please circle how often each symptom occurs based on the given scale:

0 = Never or Non-existent

1= Seldom

2= Occasionally

3= Frequently

4= Always

1	Complains of blurred vision at near	0 1 2 3 4
2	Complains of double vision	0 1 2 3 4
3	Reports headaches associated with near work or end of school day	0 1 2 3 4
4	Reports that words run together when reading	0 1 2 3 4
5	Burning, stinging, watery eyes or rubs eyes often	0 1 2 3 4
6	Loses interest easily when reading	0 1 2 3 4
7	Note that vision is worse at the end of the day	0 1 2 3 4
8	Skips or repeats lines when reading, loses place	0 1 2 3 4
9	Must use finger or guide to keep place on line when reading	0 1 2 3 4
10	Tilts head or closes one eye when reading	0 1 2 3 4
11	Has difficulty copying from the chalkboard	0 1 2 3 4
12	Avoids reading and schoolwork	0 1 2 3 4
13	Omits small words or puts in other words not there when reading	0 1 2 3 4

14	Writes uphill, downhill, or off- line; poorly organized writing	0	1	2	3	4
15	Mis-aligns digits in columns of numbers	0	1	2	3	4
16	Reading comprehension is poor or declines over time	0	1	2	3	4
17	Shows inconsistent or poor sports performance	0	1	2	3	4
18	Holds reading material too close to eyes	0	1	2	3	4
19	Shows a short attention span	0	1	2	3	4
20	Has difficulty completing homework assignments in a reasonable time	0	1	2	3	4
21	Often says "I can't" before trying	0	1	2	3	4
22	Avoids writing or drawing	0	1	2	3	4
23	Difficulty with hand tools – scissors, calculators, keys, etc.	0	1	2	3	4
24	Difficulty completing homework independently	0	1	2	3	4
25	Tendency to knock things over on desk or table; appears clumsy	0	1	2	3	4
26	Difficulty with time management	0	1	2	3	4
27	Poor spelling skills	0	1	2	3	4
28	Frequently reverses letters/numbers (i.e. b/d or 5/S)	0	1	2	3	4
29	Car sickness / motion sickness	0	1	2	3	4
30	Difficulty retaining sight words learned before	0	1	2	3	4

