LONG ISLAND OPTOMETRIC VISION DEVELOPMENT, PLLC

DEVELOPMENTAL OPTOMETRISTS

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Developmental Vision Evaluation Pre-School 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	☐	☐	_____
Blurred vision at near	☐	☐	_____
Eyestrain or visual fatigue	☐	☐	_____
Headaches	☐	☐	_____
Sensitivity to sunlight or bright lights	☐	☐	_____
Double vision	☐	☐	_____
Words split or move on the page	☐	☐	_____
Eyes hurt	☐	☐	_____
Car sickness/Motion sickness	☐	☐	_____

Do you or others notice any of the following with your child?	No	Yes	If yes, when?
Covers or closes one eye with near tasks	☐	☐	_____
Dislikes school or academic related tasks	☐	☐	_____
Eye appears to turn inward/outward	☐	☐	_____
Fidgets in chair with near/tabletop activities	☐	☐	_____
Frequently blinks or rubs eyes with near work	☐	☐	_____
Puzzles are difficult or challenging	☐	☐	_____
Difficulty sustaining attention with tabletop activities	☐	☐	_____
Concern child has ADD or ADHD	☐	☐	_____
Avoids looking at books	☐	☐	_____
Brings near work very close to eyes	☐	☐	_____
Confuses right and left	☐	☐	_____
Reverses letters/numbers excessively (ie: b/d, S/5)	☐	☐	_____
Transposes numbers (152/512)	☐	☐	_____
Difficulty retaining letters, numbers, colors learned	☐	☐	_____
Needs a lot of repetition with learning new things	☐	☐	_____
Poorly organized handwriting	☐	☐	_____
Avoids writing or drawing	☐	☐	_____
Handwriting is slow to develop	☐	☐	_____
Clumsy, bumps into things often in environment	☐	☐	_____
Poor eye-hand coordination in sports	☐	☐	_____
Frequently erases	☐	☐	_____
Clumsy; bumps into things often	☐	☐	_____
Not looking where s/he is going	☐	☐	_____
Frequently says “I Can’t” before trying a task	☐	☐	_____

Has your child ever had:	No	Yes	When/with whom?
Eye surgery	☐	☐	_____
Eye patching	☐	☐	_____
Eye Injury	☐	☐	_____
Vision therapy	☐	☐	_____

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	☐	☐	_____
Vitamins/supplements	☐	☐	_____
Allergies to medications	☐	☐	_____
Allergies to foods	☐	☐	_____
Seasonal allergies	☐	☐	_____
Frequent ear infections	☐	☐	_____
Anxiety/depression/fears	☐	☐	_____
Emotional concerns in the family	☐	☐	_____

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	☐	☐	_____	Neurological	☐	☐	_____
Ears/Nose/Throat	☐	☐	_____	Endocrine	☐	☐	_____
Cardiovascular	☐	☐	_____	Genitourinary	☐	☐	_____
Respiratory	☐	☐	_____	Skin	☐	☐	_____
Gastrointestinal	☐	☐	_____	Musculoskeletal	☐	☐	_____
Psychiatric	☐	☐	_____	Hematologic	☐	☐	_____
Other	☐	☐	_____				

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

	Patient	Family	Whom?		Patient	Family	Whom?
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____
High Blood Pressure	☐	☐	_____	Macula Degeneration	☐	☐	_____
Thyroid Disease	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Crossed or wall eyes	☐	☐	_____
Genetic Abnormalities	☐	☐	_____	Learning Disability	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____	Dyslexia	☐	☐	_____

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	☐	Yes	☐	No. times per week: _____
Physical Therapy:	No	☐	Yes	☐	No. times per week: _____
Speech Therapy:	No	☐	Yes	☐	No. times per week: _____
ABA Therapy:	No	☐	Yes	☐	No. times per week: _____
Reading Support:	No	☐	Yes	☐	No. times per week: _____
Math Support:	No	☐	Yes	☐	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	☐	Yes	☐	No. times per week: _____
Physical Therapy:	No	☐	Yes	☐	No. times per week: _____
Speech Therapy:	No	☐	Yes	☐	No. times per week: _____
ABA Therapy:	No	☐	Yes	☐	No. times per week: _____
Reading Support:	No	☐	Yes	☐	No. times per week: _____
Math Support:	No	☐	Yes	☐	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 looking at books for pleasure
- ☐ Enjoys being read to by parent, but will not pick up books 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-PreSchool

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 day	0 1 2 3 4
4	Rubs eyes often with near work	0 1 2 3 4
5	Burning, stinging, watery eyes often	0 1 2 3 4
6	Eyes turn in or outward	0 1 2 3 4
7	Note that vision is worse at the end of the day	0 1 2 3 4
8	Tilts head or closes one eye with near work	0 1 2 3 4
9	Dizziness or nausea associated with near work	0 1 2 3 4
10	Holds reading material too close to eyes	0 1 2 3 4
11	Has difficulty copying from paper to paper	0 1 2 3 4
12	Avoids books and schoolwork	0 1 2 3 4
13	Avoids writing or drawing	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	Loses interest easily with near work or schoolwork	0 1 2 3 4
17	Shows inconsistent or poor sports performance	0 1 2 3 4
18	Hesitant with walking down stairs; must hold on to rail	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	Difficulty remembering or retaining numbers, letters or colors learned	0 1 2 3 4
23	Difficulty with hand tools – scissors, pasting, etc.	0 1 2 3 4
24	Difficulty completing homework independently; parent must help child	0 1 2 3 4
25	Tendency to knock things over on desk or table; appears clumsy	0 1 2 3 4
26	Writes from right to left	0 1 2 3 4
27	Needs a lot of repetition with learning new things	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	Frustrated in school and has low self-esteem	0 1 2 3 4