



PATIENT INFORMATION (ALSO COMPLETE SECTION 2 IF PATIENT IS A MINOR)

Patient Name: Last, First, M. Initial			<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one):	
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Wid	
Is patient minor?	<input type="checkbox"/> Yes	Do you go by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list below.	Date of Birth:		Age:	Sex:
	<input type="checkbox"/> No		/ /			<input type="checkbox"/> M <input type="checkbox"/> F
Home address:			Social Security no.:		Phone Number:	
Mailing address (if different):			City:		State:	ZIP Code:
Email Address:						
School (if minor)		Grade (if minor)	Occupation:		Work Phone Number:	
I chose your clinic because/ I was referred to clinic by (please check one box):						
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Internet	<input type="checkbox"/> Dr. Name:	<input type="checkbox"/> Other:		

PARENT/GUARDIAN INFORMATION

Mother /Guardian Name:		Date of Birth:	Address (if different from above):	Phone Number:
		/ /		Home
				Cell
Occupation:	Employer:			Work Phone Number:
Father /Guardian Name:		Date of Birth:	Address (if different from above):	Phone Number:
		/ /		Home
				Cell
Occupation:	Employer:			Work Phone Number:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Cell phone:

PAYMENT INFORMATION

The above information is true to the best of my knowledge. Arizona Vision Therapy Center is not a participating provider with any insurance company. I understand that I am financially responsible for all charges. If I request billing statements, Arizona Vision Therapy Center will provide me with billing information. By signing below, I also acknowledge that any past due balances will incur a 10% compound interest each month.

Patient/Parent/Guardian Signature	Date
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VISUAL SKILLS QUESTIONNAIRE

(Please fill out the questionnaire carefully.)

Patient Name: _____

Date: _____

Date of Birth: _____

PRESENT SITUATION

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

HAVE ANY OF THE FOLLOWING BEEN REPORTED?

Table with 2 columns of symptoms and 2 columns of Yes/No checkboxes. Symptoms include Headaches, Blurred vision, Double vision, Eyes hurt, Eyes tired, Words move around on the page, Motion sickness, and Dizziness.

How long has this problem/difficulty been observed? _____

How frequently does it occur? [] Always [] Daily [] Weekly [] Monthly [] Other: _____

Is there anything that makes this problem better? _____

Is there anything that makes this problem worse? _____

Is it getting better, staying the same, or worsening? _____

DEVELOPMENTAL HISTORY

Full Term Pregnancy? [] Yes [] No If no, explain: _____

Were forceps/vacuum suction used? [] Yes [] No Was a cesarean performed? [] Yes [] No

Were there any problems prior to / during / immediately after your/your child's birth? [] Yes [] No

If yes, explain: _____

At what age did you/your child experience "tummy time"? _____

At what age did you/your child crawl (stomach on floor)? _____

At what age did you/your child creep (stomach off floor)? _____

At what age did you/your child walk (without support)? _____

Were there ever any concerns regarding your/your child's growth or development? [] Yes [] No

If yes, explain: _____

VISUAL HISTORY

Most Recent Eye Doctor's Name: _____ Date of last evaluation: _____

Reason for examination: _____ Results and recommendations: _____

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results:

Have you/your child ever been told that amblyopia ("lazy eye") was present? Yes No

Has there been any surgical treatment? Yes No

If yes, please describe the surgery, number of operations, age(s), the eye operated on, and results:

Members of the family (blood relatives) who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING SYMPTOMS WITH YOU/YOUR CHILD?

(please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Frequent blinking | <input type="checkbox"/> Words move on page |
| <input type="checkbox"/> Frequent eye rubbing | <input type="checkbox"/> Reports confusion of what is seen |
| <input type="checkbox"/> Frowning with near work | <input type="checkbox"/> Reverses letters or words |
| <input type="checkbox"/> Closing or covering one eye | <input type="checkbox"/> Confuses right and left |
| <input type="checkbox"/> Squints when reading | <input type="checkbox"/> Difficulty with memory |
| <input type="checkbox"/> Eye turns in, out, up or down | <input type="checkbox"/> Poor recall of visual tasks |
| <input type="checkbox"/> Bothered by light | <input type="checkbox"/> Better recall for hearing than seeing |
| <input type="checkbox"/> Tilts head when reading and/or writing | <input type="checkbox"/> Responds better orally than by writing |
| <input type="checkbox"/> Head close to paper | <input type="checkbox"/> Knows answers but tests poorly |
| <input type="checkbox"/> Moves head when reading | <input type="checkbox"/> Short attention span / loses interest |
| <input type="checkbox"/> Uses finger when reading | <input type="checkbox"/> Vocalizes when reading silently |
| <input type="checkbox"/> Avoids reading | <input type="checkbox"/> School performance below potential |
| <input type="checkbox"/> Fatigues with near tasks | <input type="checkbox"/> Difficulty copying from Chalkboard/smart boards |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Writes/prints poorly |
| <input type="checkbox"/> Comprehensive lessens with time | <input type="checkbox"/> Writes neatly but slowly |
| <input type="checkbox"/> Reads slowly | <input type="checkbox"/> Awkward or immature pencil grip |
| <input type="checkbox"/> Loses place easily with reading | <input type="checkbox"/> Frequent erasures |
| <input type="checkbox"/> Skips, rereads, or omits words | <input type="checkbox"/> Poor large motor coordination |
| <input type="checkbox"/> Re-reads entire lines of print | <input type="checkbox"/> Poor fine motor coordination |
| <input type="checkbox"/> Confuses words with same end and beginning | <input type="checkbox"/> Dislikes / avoids sports |
| <input type="checkbox"/> Problem recognizing same word on different page | <input type="checkbox"/> Difficulty catching / hitting a ball |

MEDICAL HISTORY

Pediatrician/Dr. Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

List illnesses, bad falls, high fevers, etc.: _____

Is there a history of any chronic problems like ear infections, asthma, hay fever, allergies? Yes No

If yes, please list: _____

Other health problems? Yes No If yes, please explain: _____

Has a neurological, psychological, occupational therapy, etc. evaluation been performed? Yes No

By whom? _____ Results and recommendations: _____

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

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other: _____

SCHOOL

Are you/your child attending school at this moment? Yes No *(if no, skip to Family and Home section.)*

Is school enjoyable? Yes No

Specifically describe any school difficulties: _____

Has any special tutoring, therapy, and/or remedial assistance been needed? Yes No

How long has there been assistance? _____ Where and from whom? _____

Results: _____

Do you/your child read for pleasure? Yes No

If so, what kind of books? _____

Overall schoolwork is: above average average below average

Which subjects are:

Above average: _____

Below average: _____

How much time on average is spent each day on homework assignments? _____

Do you feel you/your child are achieving up to potential? Yes No

Does the teacher feel that you/your child are achieving up to potential? Yes No

FAMILY AND HOME

Please list the names and birth dates of your family:

Sibling: _____ DOB: _____

Sibling: _____ DOB: _____

Sibling: _____ DOB: _____

Please indicate which adult you/your child lives with: Mother Father Both Self

Have you/your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)?

Yes No If yes, at what age: _____ Reason: _____

Is family life stable at this time? Yes No If no, please explain: _____

Did any other family members have a learning problem? Yes No If yes, who? _____

LIFESTYLE

Do you feel your/your child's vision interferes with activities of daily living? Yes No

If yes, please explain (please include effects involving home, work, and hobbies, social and personal relationships):

What do you hope a Vision Therapy Program can do for you/your child? _____

Is there any other information you feel would be helpful/important in your/your child's treatment? Yes No If yes explain:

I hereby authorize Arizona Vision Therapy Center to treat:

Print Patient Name

Print Parent/Guardian Name

Patient or Parent/Guardian Signature

Date



Release of Information

It is often beneficial to discuss evaluation and treatment information with everyone that is involved with a patient's health care and wellness. By signing this agreement, I agree to release examination and treatment records to the following names listed below. This authorization shall be considered valid throughout the duration of treatment.

<i>Print Patient Name</i>	<i>Print Parent/Guardian Name</i>
<i>Patient or Parent/Guardian Signature</i>	<i>Date</i>

Please list below everyone that you would like to receive evaluation and treatment information.

Optometrist	Phone
Therapist	Phone
Teacher/School	Phone
Pediatrician	Phone
Other	Phone
Other	Phone

I wish to withhold my evaluation and treatment information from the following individuals:

Name	Relationship to patient
Name	Relationship to patient



Arizona Vision
Therapy Center

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Permission to Photograph/Videotape and/or post testimonials

Will you allow permission to photograph and/or videotape? Yes No

Will you allow permission to post testimonial? Yes No

Print Patient Name

Print Parent/Guardian Name

Patient or Parent/Guardian Signature

Date