Arizona Vision Therapy Center

2312 N Rosemont Blvd #103 Tucson, AZ 85712
(520) 886-8800 • Fax: (520) 886-8805
visiontherapy@live.com • AZvisiontherapy.com

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

Patient Name: Last, First, M. Initial	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one):
			Single / Mar / Div / Wid

Is patient minor?	❑ Yes ❑ No	Do you go by another name? ❑ Yes ❑ No If yes, list below.	Date of Birth:	Age:	Sex:	
			/ /		❑ M	❑ 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):

❑ Family	❑ Friend	❑ Internet	❑ Dr. Name:	❑ 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?

	Yes	No		Yes	No
Headaches	☐	☐	Eyes tired	☐	☐
Blurred vision / focus goes in and out	☐	☐	Words move around on the page	☐	☐
Double vision	☐	☐	Motion sickness / car sickness	☐	☐
Eyes hurt	☐	☐	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:

Name	Age	Visual Situation
______________________________	_____	____
______________________________	_____	____

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

(please check all that apply)

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

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	________	Amblyopia (lazy eye)	☐	☐	________
Diabetes	☐	☐	________	Strabismus (eye turn)	☐	☐	________
Glaucoma	☐	☐	________	Learning Disability	☐	☐	________
Multiple Sclerosis	☐	☐	________	ADD/ADHD	☐	☐	________
Epilepsy/Seizures	☐	☐	________	Autism	☐	☐	________

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*

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Release of Information

It is often beneficial to discuss evaluaiton 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.

____ ____
Print Patient Name *Print Parent/Guardian Name*

____ ____
Patient or Parent/Guardian Signature *Date*

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

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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*