Columbus Vision Therapy

Thank you for carefully completing this questionnaire, to personalize your care.
Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.

Patient's Name:_____ Gender: Male ☐Female ☐
Nickname:_____ Date of Birth:_____ Age Now:_____

Home Address:_____ City:_____
State:_____Zip:_____ Main Phone:_____

CONTACT INFORMATION

Mother/Caretaker's Name:_____Email:_____
Occupation:_____ Business Phone: _____Cell Phone:_____
Preferred Method of Contact: Home Phone ☐Business Phone ☐Cell Phone ☐Email ☐

Father/Caretaker's Name:_____Email:_____
Occupation: _____Business Phone: _____Cell Phone:_____
Preferred Method of Contact: Home Phone ☐Business Phone ☐Cell Phone ☐Email ☐

Spouse/Significant Others Name: _____ Email: _____
Occupation: _____ Business Phone: _____ Cell Phone: _____
Preferred Method of Contact: Home Phone ☐Business Phone ☐Cell Phone ☐Email ☐

Person to Contact in Case of Emergency:_____ Phone: _____

PATIENT VISUAL HISTORY

Has the patient's vision been previously evaluated by an Optometrist/Ophthalmologist? ☐No ☐Yes

Doctor's Name:_____ Practice Name: _____

Practice Number: _____ Date of Evaluation:_____ Reason for exam? _____

Results and recommendations:_____

Does the patient wear: ☐Glasses ☐Contacts ☐Both? Worn for which activities?_____

Why do you feel the need for a visual evaluation?_____

How long has this problem/difficulty been observed/existed?_____

Do you feel it hinders or limits daily activities and/or potential in any way? ☐No ☐Yes, please explain:
_____

Has the patient ever had vision therapy? ☐No ☐Yes, Doctor's name and city: _____

Please describe the age at which the patient started vision, length of the program, and an estimate of results:

_____

Do you notice any of the following visual symptoms?

☐Frowns
☐Red eyes or lids
☐Excessive watering of eyes or eye rubbing
☐Must reread to understand, especially when tired
☐Use finger or marker when reading
☐Loses place when reading
☐Head movements when reading
☐One eye turns in/out (SEE ADDENDUM)
☐Cover or close one eye when reading or writing
☐Tilt or turns head
☐Awkward posture (standing, reading, writing)
☐Letters/lines "float, run together, or jump around"
☐Writes poorly (crooked, poor spacing, up/down)
☐Writes neatly but slowly
☐Awkward pencil grip
☐Slow Reader
☐Confuses letters or words
☐Difficulty recognizing same word on different page
☐Mistakes words with similar beginnings
☐Poor ability to remember what is read
☐Seems to know material but does poorly on tests
☐Reverses letters and numbers
☐Learn better when "hear" the information
☐Vocalizes or moves lips when reading silently
☐Difficulty following verbal instructions
☐Short attention span, distractable or loss of interest
☐Confuse "right" and "left"
☐Difficulty attending to detail

READING/COMPUTERS/TV

Does the patient like to read? ☐No ☐Yes, how long are you able to read until your eyes bother you? _____
Does the patient use a computer? ☐No ☐Yes, for how many hours per day? _____
How do your eyes feel after working at the computer? _____
Does the patient watch TV? ☐No ☐Yes, average viewing time? _____
Does the patient have a cell phone? ☐No ☐Yes, average time on phone? _____

MEDICAL HISTORY

Physician's Name:_____ Practice Name: _____

Practice Address: _____ Practice Number: _____

Date of most recent visit: _____ For what problem/condition?_____

Medications (include vitamins/supplements):_____

Allergic to any medications? ☐No known drug allergies ☐Yes, please list: _____

Have you tested positive for food allergies or sensitivities? ☐No ☐Yes, which foods?

_____

Is the patient especially afraid of doctors? ☐No ☐Yes, please explain: _____

Is the patient up to date on immunizations? ☐Yes ☐No, please explain: _____

Please indicate if the patient has problems with any of the below

Event/Condition	Yes/No	Please describe, including time of onset
Constitutional symptoms (e.g. fever, weight loss)		
Hematologic (e.g. anemia)		
Allergic/ immunologic		
Endocrine (Diabetes)		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
Ears, nose, mouth or throat		
Gastrointestinal		
Skin disorders		
Muscoloskeletal		
Genitourinary		

Have any of the following evaluations been performed?

Neurological evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Psychological evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Educational evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Occupational Therapy evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Speech Therapy evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Physical Therapy evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Chiropractic evaluation? ☐No ☐Yes Currently in treatment? ☐No ☐Yes
Name of tester: _____ Facility Name & Address: _____
Results and recommendations:_____

Is there any evidence from the school, psychological, or other tests that indicates some visual issue may be present? ☐No ☐Yes, please explain:_____

DEVELOPMENTAL HISTORY FOR PATIENTS UNDER 18 YEARS OF AGE

Is the patient adopted? ☐No ☐Yes, at what age? ____ Is the patient a multiple? ☐No ☐Yes Twin Triplet Other

Full-term (40 weeks) pregnancy? ☐Yes ☐No, please explain:_____

☐Vaginal delivery ☐Cesarean (C-section) delivery, planned or emergency?_____

Birth weight:_____ Apgar scores @ birth:_____ After 10 minutes:_____

Any pregnancy complications (including bedrest, drug/alcohol exposure, maternal stress, etc.)? ☐No ☐Yes, please explain:_____

Any delivery complications? ☐No ☐Yes, please explain:_____

Has there been any concern over your child's general growth or development? ☐No ☐Yes, please explain:_____
_____

At what age did the patient crawl (stomach on floor)?_____ Anything unusual?_____
At what age did the patient creep (stomach off floor)?_____ Anything unusual?_____
At what age did the patient walk unaided?_____ Anything unusual?_____

Any issues with (please circle) rolling over, sitting, potty training, eating independently with spoon and/or fork, learning to write his or her full name, tying shoes, riding a bike without training wheels?
_____

GENERAL BEHAVIOR

Are there any behavior problems at school/work? ☐No ☐Yes, what are they and are there specific triggers? _____
_____

Are there any behavior problems at home? ☐No ☐Yes, what are they and are there specific triggers? _____
_____

Patient's reaction to fatigue? Sad☐ Irritable ☐ Other ☐ _____
Patient's reaction to tension? Avoidance ☐ Irritable ☐ Other☐ _____
What best describes the patient's activity level? Inactive ☐ Moderately active ☐ Extremely active ☐
Patient's dominant hand? Right ☐ Left ☐ Ambidextrous ☐

SCHOOL
Homeschooled? ☐No ☐Yes Current Grade:_____ Graduated? ☐No ☐Yes, what year? _____

School Name:_____ Phone Number: _____

Main Contact at School (Name and Title): _____

Has the patient changed schools often? ☐No ☐Yes, please explain:_____

Has a grade been repeated? ☐No ☐Yes, which grade and why?_____
_____

Does the patient like school? ☐No, why? _____
☐Yes, what part?_____

Does the patient have academic difficulties? ☐No ☐Yes, check all that apply:

☐ Reading/reading comprehension	☐ Dyslexia
☐ Writing	☐ ADD/ADHD
☐ Increased time to do homework	☐ Behavioral issue
☐ Not working up to potential	☐ Other _____

Does the patient currently have an Individualized Education Plan (IEP), 504 Plan, or receive intervention in school?
☐No ☐Yes, explain accommodations: _____

Has the patient had any special tutoring or remedial assistance? ☐No ☐Yes, when?_____

Name of tutor/assistant: _____ Facility Name: _____

How long?_____ What were the results:_____

What is the patient's overall attitude toward reading, school, teachers, peers?_____
Which subjects are: Above average:_____
Average:_____
Below average:_____

Does the patient need to spend a lot of time/effort to maintain this level of performance? ☐No ☐Yes

How much time on average does the patient spend each day on homework assignments? _____hours

To what extent does the patient need assistance with homework? _____

Do you feel the patient is achieving up to potential? ☐Yes ☐No, explain: _____

Does the teacher feel the patient is achieving up to potential? ☐Yes ☐No, explain: _____
_____

EMPLOYMENT (if applicable)

Occupation of patient: _____ Name of Employer: _____

Briefly describe the patient's daily activities at work: _____

What are the biggest challenges with these activities? _____

How many hours daily are spent at a desk? ____ Working at near distances? _____ Working at far distances? _____

Do you feel you are achieving your potential at work? ☐Yes ☐No

Do you feel an increasing need for more effort to accomplish tasks? ☐No ☐Yes, please explain:
_____

HOBBIES/SPORTS

Describe the types of activities the patient likes to do during leisure time: _____
_____

Does the patient participate in sports or outdoor activities? ☐No ☐Yes, which ones? _____
_____

Does the patient feel challenged or uncoordinated in sports or athletic activities? ☐No ☐Yes

Of all the sports played, list the ones in which the patient excelled: _____

List the ones in which the patient did poorly or avoided: _____

What does the patient struggle with during this activity or sport (i.e., batting, excess turnovers, serving)?
_____

FAMILY AND HOME
Are there others living in your home? ☐No ☐Yes, please list names, ages and relation below:
_____
_____

Does the patient spend a significant amount of time with any other person, not in the home? ☐No ☐Yes, please explain:_____

Has the patient ever been through a traumatic family situation? ☐No ☐Yes, explain:
_____

Was counseling/therapy undertaken? ☐No ☐Yes Is it on-going? ☐No ☐Yes, therapist name: _____

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

FAMILY MEDICAL HISTORY (Please check if there is any history of the following.)

	Self	Family	If Family, who?		Self	Family	If Family, who?
Poor Vision/High Prescription				Glaucoma			
Strabismus (eye turn)				Blindness			
Amblyopia (lazy eye)				High Blood Pressure			
Learning Issue				Thyroid			
ADD/ ADHD				Diabetes			

Autism				Cancer			
Epilepsy or Seizures				Other			

GIVE A BRIEF DESCRIPTION OF THE PATIENT AS A PERSON:_____

_____

_____

_____

WHAT ARE YOUR BIGGEST CONCERNS AND WHAT WOULD YOU LIKE TO ACCOMPLISH FROM THE VISUAL EFFICIENCY EVALUATION AND? OR VISION THERAPY?

_____

_____

_____

If you have any questions or concerns that we may answer prior to your appointment, please contact us.
We are looking forward to meeting you!

Sincerely,

Columbus Vision Therapy

STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you ever been told that you have amblyopia ("lazy eye")? Yes ☐ No ☐ If "Yes," at what age?_____
Which eye? Right ☐ Left ☐
Have you ever been told that you have strabismus ("eye turn")? Yes ☐ No ☐ If "Yes," at what age?_____
Have you had an eye surgery? Yes ☐No ☐If "Yes," please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on:_____
_____
Was the surgeon satisfied with the results of surgery? Yes ☐No ☐Explain:_____
Were you satisfied with the results of surgery? Yes ☐No ☐Explain:_____
Have surgical results been maintained? Yes ☐No ☐Explain:_____
Do you experience double vision? Yes ☐ No ☐ If "Yes," please describe your double vision, when it occurs, and at what distance: _____
Are you here for a second opinion regarding surgery or other treatment? Yes ☐ No ☐

IF YOUR EYE TURNS:

- Did it begin turning: suddenly ☐ or gradually ☐? Explain:_____
(Note: A sudden eye turn may be due a serious medical emergency and requires immediate medical attention.)
- Does the eye turn: in ☐ out ☐ up ☐ or down ☐? (check all that apply)
- Is the eye turn getting: worse ☐ or better ☐ or is there no change ☐?
- Is it always the same eye that turns? Yes ☐ No ☐ If "Yes," which eye? Right ☐ Left ☐
- Is the eye turn always present? Yes ☐ No ☐
    - If no, under what conditions is it present? _____
- Does the eye always turn the same amount? Yes ☐No ☐
    - If no, explain: _____
- Do you notice if the eye turns more when your child is looking:
    - up close? Yes ☐ No ☐
    - in the distance? Yes ☐ No ☐
    - to the left? Yes ☐ No ☐
    - to the right? Yes ☐ No ☐
    - up? Yes ☐ No ☐
    - down? Yes ☐ No ☐
- Does the eye turn less (or vision improve) when the prescription is worn? Yes ☐ No ☐ Unsure ☐
- Have you ever used an eye patch? Yes ☐ No ☐
- If "Yes," please describe your age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: _____
_____
- Does one pupil ever appear to be larger than the other? Yes ☐ No ☐
- Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐
- What is your best corrected vision, if known?_____
- What are your biggest concerns regarding your strabismus or amblyopia?_____
_____
_____