Comprehensive Vision Therapy Center
5300 California Ave., Ste. 210
Bakersfield, CA 93309

CHILDREN'S VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully prior to your appointment time. THANK YOU.

We understand that it is long, but it will help us provide the best care for your vision needs.

Person assisting the patient with this form:_____ Relation: _____
Appointment: Day _____ Date _____ Time _____
Were you referred to our office? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _____ Phone: _____

GENERAL INFORMATION
Patient Name:_____ ☐ Male ☐ Female
Birth Date:_____ Age:_____ Social Security Number: _____
Email:_____
Home Address: _____
Home Phone: _____ Work Phone: _____
Lives with ☐ Mother, Name _____ ☐ Father, Name _____
☐ Other, Name and Relationship _____
Responsible Party: _____
Address: _____
Insurance Company: _____ Subscriber:_____
ID# _____ Subscriber's Birth Date _____

MEDICAL HISTORY
Please list all current medications:_____

_____

_____

Allergies to Medications:_____
Other Allergies:_____
List all other major injuries, surgeries and/or hospitalizations the child has had:_____._____

_____

FAMILY HISTORY Please note any family history for the following conditions:

Blindness	☐Yes ☐ No	Cancer	☐Yes ☐ No
Cataract	☐Yes ☐ No	Diabetes	☐Yes ☐ No
Crossed Eyes.....	☐Yes ☐ No	Heart Disease	☐Yes ☐ No
Glaucoma	☐Yes ☐ No	High Blood Pressure	☐Yes ☐ No
Macular Degeneration.	☐Yes ☐ No	Kidney Disease	☐Yes ☐ No
Retinal Detachment.....	☐Yes ☐ No	Other_____	
Thyroid Disease……..	☐Yes ☐ No		

SOCIAL HISTORY
Do your child drive? ☐Yes ☐ No
Do they use tobacco products? ☐Yes ☐ No Type / Amount/ How long? _____
Do they drink alcohol? ☐Yes ☐ No How much/ How often?_____
Do they use illegal drugs? ☐Yes ☐ No Type/ How often?_____

REVIEW OF SYSTEMS

VISION/EYES Do you, or have you ever had any problems in the following areas? **Circle, or explain.**

Loss of vision, Floaters, Distorted vision/halos, Blind spots, Discharge, Eye pain, Dryness, Foreign body sensation, Light sensitivity, Chronic eyelid infection, Styes, NONE

Cardiovascular/Vascular:		Onset	**Immune system/Infections:**		Onset
High Blood Pressure	Y N	_____	Sjogrens syndrome	Y N	_____
Heart Probl.: _____	Y N	_____	Autoimmune disease	Y N	_____
Vascular Disease	Y N	_____	HIV Positive/AIDS	Y N	_____
Other: _____	Y N	_____	Lyme disease	Y N	_____
Constitutional:			Sarcoidosis	Y N	_____
Fever	Y N	_____	Tuberculosis	Y N	_____
Weight gain/loss	Y N	_____	Other: _____	Y N	_____
Fatigue:	Y N	_____	**Integumentary/Skin:**		
Other: _____	Y N	_____	Skin rash/hives	Y N	_____
Endocrine:			Dermatitis	Y N	_____
Diabetes	Y N	_____	Dry skin	Y N	_____
Thyroid	Y N	_____	Other: _____	Y N	_____
Pituitary disorder	Y N	_____	**Musculoskeletal:**		
Other:_____	Y N	_____	Arthritis	Y N	_____
Gastrointestinal:			Muscle pain	Y N	_____
Diarrhea	Y N	_____	Skeletal Disorder	Y N	_____
Constipation	Y N	_____	Other: _____	Y N	_____
Other:_____	Y N	_____	**Neurological:**		
Genitourinary:			Headache/Migraine	Y N	_____
Genital	Y N	_____	Brain tumor	Y N	_____
Kidney	Y N	_____	Seizures	Y N	_____
Bladder	Y N	_____	Stroke	Y N	_____
Other: _____	Y N	_____	Other: _____	Y N	_____
Ears/Nose/Mouth/Throat:			**Psychiatric:** (Please describe)	Y N	
Runny nose	Y N	_____	_____	Y N	_____
Chronic cough	Y N	_____	_____	Y N	_____
Dry throat/mouth	Y N	_____	**Respiratory:**		
Hearing loss	Y N	_____	Asthma	Y N	_____
Sinus disease	Y N	_____	Emphysema	Y N	_____
Other: _____	Y N	_____	Chronic bronchitis	Y N	_____
Hematologic/Lymphatic			Other: _____	Y N	_____
Anemia	Y N	_____			
Blood disorder	Y N	_____			
Bleeding problem	Y N	_____			
Other: _____	Y N	_____			

Date of onset of Neurologic difficulty._____

Any other health or developmental issues, Please Explain:_____

Any other health or developmental issues, Please Explain:_____

Any history of prior injuries, including head, other than one we may be examining the child for today, Please Explain:_____

HISTORY OF CURRENT INJURY

Please complete this section (a) if there was an incident or multiple incidents that resulted in the neurological impairment and (b) you do not have copies of reports that explain the detailed history of the injury. OTHERWISE, skip to: SUBSEQUENT/OTHER PROFESSIONAL CARE

Date of injury/accident (if applies):_____

Brief description of injury:_____

Was the injury OPEN HEAD (skull fracture) or CLOSED HEAD (no skull fracture)? (please circle one)

Loss of consciousness? ☐Yes ☐ No If yes, for how long? _____

Coma? ☐Yes ☐ No If yes, for how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

☐ Double vision	☐ Blurred vision	☐ Flashes of light	☐ Pain in or around eyes
☐ Headache	☐ Memory loss	☐ Disorientation	☐Restricted field of view
☐ Vomiting	☐ Dizziness	☐ Loss of balance	☐Neck pain/whiplash

Other: _____

INITIAL TREATMENT

When did your child first see a doctor regarding the accident/injury? _____

Name of Doctor: _____ Specialty: _____

Was your child hospitalized? ☐ Yes ☐ No How long? _____

What were his/her diagnoses?_____

What prognosis/recommendations was your child given? _____

SUBSEQUENT/OTHER PROFESSIONAL CARE

Has a neurological evaluation been performed? ☐Yes ☐ No

If yes, by whom? _____ Date: _____

Recommendations: _____

Has a psychological evaluation been performed? ☐Yes ☐ No

If yes, by whom? _____ Date: _____

Recommendations: _____

Has a vision/eye evaluation been performed? ☐Yes ☐ No

If yes, by whom? _____ Date: _____

Recommendations: _____

PLEASE LIST any other professionals that have evaluated or are currently working with your child such as a: Physician, Physiatrist, Neurologist, Neuropsychologist, Psychologist / Psychiatrist, Physical Therapist, Speech/Language Therapist, Occupational Therapist, Osteopathic Physician, Tutor or others, Please list:

Name	Profession	Recommendations Date(s)

LIFESTYLE

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

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

What activities comprise the majority of your child's daily life since their accident/injury? _____

What activities can your child no longer engage in due to their visual or other difficulties? _____

What other changes/limitations in your child's daily life do you attribute to their accident/injury? _____

What do you hope a Visual Rehabilitation Program can do for your child? _____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

Was your child employed prior to their injury?_____
If so, what was their position? _____
What is their current employment position? _____
What is the highest grade they have completed in school?_____
How are/were his/her grades?_____
If a student, what is the major course of study? _____
How many hours daily are spent working at near distance? _____
How many hours daily are spent reading/studying? _____
How many hours daily are spent with a computer? _____

PLEASE CHECK IF YOUR CHILD CURRENTLY EXPERIENCES OR EXPERIENCED PRIOR TO THEIR INJURY (IF APPLIES) ANY OF THE FOLLOWING:

	Current		**Prior to Injury**		**Office Use Only**
	Yes	No	Yes	No	**Resolved/Date**
Headaches	☐	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	☐
Flashes of light	☐	☐	☐	☐	☐
Pain with movement of eyes	☐	☐	☐	☐	☐
Pain in or around eyes	☐	☐	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐	☐	☐
Reduced depth perception	☐	☐	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐	☐	☐
Eye redness	☐	☐	☐	☐	☐
Eye Burning	☐	☐	☐	☐	☐
Eye Itching	☐	☐	☐	☐	☐
Eye Watering	☐	☐	☐	☐	☐
Brightness is bothersome	☐	☐	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐	☐	☐
Difficulty seeing in dim lighting	☐	☐	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐	☐	☐
Motion sickness / car sickness	☐	☐	☐	☐	☐
Lose place/skip words often when reading	☐	☐	☐	☐	☐
Words jump or move around when reading	☐	☐	☐	☐	☐
Difficulty understanding what is read	☐	☐	☐	☐	☐

	Current		Prior to Injury		Office Use Only
	Yes	No	Yes	No	Resolved/Date
Hold books too close	☐	☐	☐	☐	☐
Discomfort/fatigue when reading	☐	☐	☐	☐	☐
Short attention span for close work	☐	☐	☐	☐	☐
Orient writing/drawing poorly on page	☐	☐	☐	☐	☐
Dislike heights	☐	☐	☐	☐	☐
Awkward, poor balance	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Confusion / disorientation	☐	☐	☐	☐	☐
Get lost often	☐	☐	☐	☐	☐
Difficulty dressing/bathing/personal hygiene	☐	☐	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐	☐	☐
Bothered by noises	☐	☐	☐	☐	☐
Bothered by touch	☐	☐	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐	☐	☐
Difficulty recalling recent information	☐	☐	☐	☐	☐
Difficulty remembering formerly familiar people / objects	☐	☐	☐	☐	☐
Difficulty with time management	☐	☐	☐	☐	☐
Difficulty with numbers	☐	☐	☐	☐	☐
Difficulty counting money	☐	☐	☐	☐	☐

Release of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your child's care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Drs. Penelope Suter or any doctors under her employ when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of his/her treatment.

_____ _____

Signature of parent or authorized representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your child's pecific visual needs.

If at any time you have any questions or concerns regarding your child's vision or treatment, please do not hesitate to contact us.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your child's evaluation so that we may have the maximum opportunity to evaluate their visual status.

Thank you.

(Person who is filling this form out, please sign below.)

Signed:_____ Print Name:_____Relation: _____ Date:_____