CIMARRON FAMILY VISION CENTER ● 6602 E CARONDELET DR ●TUCSON AZ 85710
Phone (520) 886-8800 ● Fax (520) 886-8805 ● email: visiontherapy@live.com

VISUAL SKILLS QUESTIONNAIRE

(Please fill out the questionnaire carefully.)

Patient Name: _____ Date: _____

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
- ☐ 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
- ☐ 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
- ☐ Difficulty copying from Chalkboard/smart boards or 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:

_____

_____

By signing below, I hereby give my permission to Cimarron Family Vision to treat: _____

(Print Your/Your Child's Name)

_____ _____

Patient/Guardian Signature Date

Release of Information

It is often beneficial for us to discuss evaluation and treatment information with everyone that is involved with a patient's health care and wellness. We believe that it is important that everyone be involved in their progress with vision therapy.

By signing this agreement, I agree to release my examination and treatment records to the following names list below, or upon recommendation of Cimarron Family Vision when it is necessary for the treatment of my visual condition. This authorization shall be considered valid throughout the duration of treatment.

I hereby authorize Cimarron Family Vision to release copies of the reports to the names stated in the questionnaire and also provided below unless expressly forbidden at the end of the page.

_____ _____
Patient Name (print) Relationship to patient (if minor)

_____ _____
Patient/Legal 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

PERMISSION TO PHOTOGRAPH/VIDEOTAPE

We may need to photograph or videotape you for our records. This photograph will not be used for any other purpose without your express permission.

Will you allow permission to photograph and/or videotape?

Yes / No

Signature: _____

I hereby give my permission to Cimarron Family Vision to treat: _____
(Name)

_____ _____
Signature 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 of you and to better meet your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us at any time. We request a minimum of 48 hours' notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status.

THANK YOU.

Sincerely,

Amy Thomas, OD, FCOVD
Developmental/Neurocognitive Optometrist

NOTE: ***While Optometric Vision Therapy is not inexpensive, it should be seen as an investment in your/your child's future.***

Realizing that the cost of vision therapy may be a financial burden for some families, Cimarron Family Vision has made special arrangements with CareCredit (www.carecredit.com). Please do not hesitate to discuss this with the office manager.

For more information on insurance coverage, please visit our website at:

www.cimarronfamilyvision.net