The Center for Vision Enhancement
84 NE Loop 410, Suite 140
San Antonio, TX 78216
Phone: (210) 822-0900
Fax: (210) 822-1299

Jason G Deviney, O.D.
Developmental Optometrist
4501 McCullough Ave Suite 101
San Antonio, TX 78212
210-340-5822

THE VISION THERAPY EVALUATION WILL BE CONDUCTED AT DR. DEVINEY'S PRIMARY OPTOMETRIC PRACTICE AT LOCATED AT

4501 McCULLOUGH AVE
SUITE 101
210-340-5822

NOT AT THE VISION THERAPY CLINIC.

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CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office. Thank You.

Appointment: Day_____ Date: _____ Time_____
Patient's Name: _____

General Information
Were you referred to our office? Yes □ No □
If yes, whom may we thank for this referral? _____Phone: _____
Address: _____
Child's Full Name:_____
Date of Birth: _____ Age: _____ years _____months
Name and address of school: _____
Grade____ Teacher:_____ School Nurse: _____ Principal _____
Is your child especially afraid of doctors? _____
Child's dominant hand (circle): right or left Has guidance been given in use of hand? Yes □ No □

Please list the names and birth dates of your family:
Father/Caretaker _____ Birth Date_____
Mother/Caretaker_____ Birth Date_____
Sibling_____ Birth Date_____
Sibling_____ Birth Date_____
Sibling_____ Birth Date_____

Responsible Person Information
Home Address: _____ City _____ Zip_____
Home Phone: _____Email address: _____
Cell Phone(s):_____
Father/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City _____ Zip _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City _____ Zip _____

Do you have Major Medical insurance? Yes ☐ No☐
If so, who is the carrier? _____ Policy #: _____
Name of insured: _____
Social Security Number: _____ Driver's License: _____

Medical History

Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations _____
_____
Child's current state of Health: _____

Medications currently using, including vitamins and supplements:_____
_____
For what condition(s)? _____
_____
Immunizations child has received:

Immunization type: _____Date: _____
Immunization type: _____Date: _____
Immunization type: _____Date: _____
Immunization type: _____Date: _____

Any reactions to immunization(s): Yes □ No □ If no, explain: _____
_____

List illnesses, bad falls, high fevers, etc…

Age	Severe	Mild	Complications

Is your child generally healthy? Yes ☐ No ☐ If no, explain: _____
_____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes □ No □
If yes please list: _____
_____
Has a neurological evaluation been performed? Yes □ No □
By whom: _____ Results and recommendations:_____
_____
Has a psychological evaluation been performed? Yes □ No □
By whom: _____ Results and recommendations: _____
_____
Has an occupational therapy evaluation been performed? Yes □ No □
By whom: _____ Results and recommendations: _____
_____

Is there any history of the following? (Please check if there is a history)

	Patient	Family	Who
Diabetes	□	□	_____
"Cross" or "wall" eye	□	□	_____
Chromosomal imbalance	□	□	_____
Glaucoma	□	□	_____

High Blood Pressure	□	□	_____
Learning Disability	□	□	_____
Amblyopia (lazy eye)	□	□	_____
Multiple Sclerosis	□	□	_____
Epilepsy or Seizures	□	□	_____
Other	□	□	_____

If other, please explain: _____
_____

NUTRITIONAL INFORMATION

Current Diet: Excellent □ Good □ Fair □ Poor □
Does your child: Like sweets □ or crave sweets □
If yes, What types? _____
Is your child active? Yes □ No □
Moderately? Yes □ No □
Extremely? Yes □ No □
Are there periods of
very high energy?
very low energy?
Explain:_____

DEVELPMENTAL HISTORY

Full-term pregnancy? Yes □ No □
Did the mother experience any health problems during the pregnancy? Yes □ No □
If yes, explain: _____
Normal birth? Yes □ No □
Any complications before, during, or immediately following delivery? Yes □ No □
If yes, explain: _____
Birth weight: _____ Apgar scores @birth: _____ After 10 minutes: _____
Were forceps used? Yes □ No □
Was there ever any reason for concern over your child's generally growth or development?
Yes □ No □
Did your child crawl (stomach on floor)? Yes □ No □ At what age? _____
Did your child creep (on all fours)? Yes □ No □ At what age? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes □ No □
Speech: first words: _____At what age:_____
Was early speech clear to others? Yes □ No □
Is speech clear now? Yes □ No □
Has your child been diagnosed with autism? Yes □ No □

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes □ No □
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes □ No □
If yes, what? _____

Are they used? Yes □ No □ If yes, when? _____
If not used, why not? _____

Members of the family who have had visual attention problems and the reason:

Name	Age	Visual situation
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes □ No □
If yes, what? _____
_____

Does your child report any of the following:	Yes	No	If yes, when?
Headaches			
Blurred vision/focus goes in and out			
Double vision			
Eyes Hurt			
Eyes tired			
Words move around on the page			
Dizziness			
List any other complaints your child makes concerning his/her vision			

Have you are anyone else ever noticed the following:	Yes	No	If yes, when?
Eyes frequently reddened			
Frequent eye rubbing			
Frequent sties			
Frowning			
Bothered by light			
Frequent blinking			
Closing or covering one eye			
Difficulty seeing distant objects			
Head close to paper when reading or writing			
Avoids reading			

Prefers being read to			
Tilts head when writing			
Moves head when reading			
Confuses letter or words			
Reverses letter or words			
Confuses Right and left			
Skips, rereads or omits words			
Loses place while reading			
Vocalizes when reading silently			
Reads slowly			
Uses finger as a marker			
Poor reading comprehension			
Comprehension decreases over time			
Writes or prints poorly			
Writes neatly but slowly			
Does not support paper when writing			
Awkward or immature pencil grip			
Frequent erasures			
Tires easily			
Difficulty copying from chalkboard			
Difficulty Recognizing same words on different page			
Poor word attack skills			
Difficulty with memory			
Remembers better what's heard than seen			
Responds better orally than by writing			
Seems to know material, but does poorly on tests			
Dislikes/avoids near tasks			
Short attention span/loses interest			
Poor large motor coordination			
Poor fine motor coordination			
Difficulty with scissors/small hand tools			
Dislikes/avoids sports			
Difficulty catching/hitting a ball			

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance?_____
Does your child spend time using computer/video games? Yes □ No □
If yes, how much and how often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____

Please explain:

_____

_____

SCHOOL

Age at time of entrance to: Pre-school_____ Kindergarten _____ First Grade _____
Does your child like school? Yes □ No □
Specifically describe any school difficulties: _____
_____
Has your child changed schools often? Yes □ No □
If yes, when? _____
Has a grade been repeated? Yes □ No □
Does your child seem to be under tension or extreme pressure when doing school work? Yes □ No □
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes □ No □
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____

Does your child like to read? Yes □ No □
Voluntarily? Yes □ No □
Does your child read for pleasure? Yes □ No □ What?_____
What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall school work is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance? Yes □ No □
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes □ No □
Does the teacher feel your child is achieving up to potential?

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes □ No □
If yes, what?
Are there any behavior problems at home? Yes □ No □
If yes, what?
What causes these problems?
Child's reaction to fatigue… Sag □ irritable □ other □_____
Child's reaction to tension…. Avoidance □ irritable □ other □_____
Does your child say and /or do things impulsively? Yes □ No □
Is your child in constant motion? Yes □ No □
Can your child sit still for long periods? Yes □ No □

FAMILY AND HOME

Please indicate which adult(s) he/she lives with Mother □ Father □ Stepmother □ Stepfather □ Foster Parent □ Adoptive Parents □ Grandmother □ Grandfather □ Aunt □ Uncle □ Other caretaker (please specify): _____

Does your child spend time with any other person, not in the home? Yes □ No □

Please explain: _____

Has 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: _____

Does your child seem to have adjusted? Yes □ No □

Was counseling/therapy undertaken? Yes □ No □

If yes, is it on-going? _____

Is family life stable at this time? Yes □ No □

If no, please explain: _____

How does your child get along with:

Parents/other caretakers _____

Siblings _____

Classmates in school _____

Playmates at home _____

Did father or another in father's family have a learning problem? Yes □ No □

If yes, who? _____

Did mother or anyone in mother's family have a learning problem? Yes □ No □

If yes, who? _____

Do any, or did any, of the other children on the family have learning problems? Yes □ No □

If yes, who?_____

To what extent? _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

_____

_____

_____

_____

_____

_____

_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD? _____

_____

_____

_____

_____

_____

_____

_____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THE EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of the CENTER FOR VISION ENHANCEMENT when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Bloom and the CENTER FOR VISION ENHANCEMENT to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

RELATIONSHIP TO PATIENT

I hereby give my permission to the Center for Vision Enhancement to treat

_____

Child's Name

_____ _____

Parent's or Guardian's 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 your child and to better meet your child's 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 24 hours a day, 7 days a week. We request a minimum of 24 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 child's visual status.

Thank you.

Sincerely,

Jason G Deviney, O.D.