

Child's Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
 Parents' Name \_\_\_\_\_  
 Occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_  
 Name of School \_\_\_\_\_ Grade \_\_\_\_\_  
 Teacher(s) \_\_\_\_\_  
 Referred by \_\_\_\_\_ Referral Phone \_\_\_\_\_  
 Referral Address \_\_\_\_\_

**Entering Complaint / Major Concern**

1. Please state briefly your main concern and the main problem your child is having: \_\_\_\_\_  
\_\_\_\_\_
2. What has occurred that has led you to request a visual examination for your child? \_\_\_\_\_  
\_\_\_\_\_
3. Who first noted the visual difficulties? \_\_\_\_\_ When? \_\_\_\_\_
4. Whose idea was it that you come in for an evaluation? (teacher, school nurse, etc)? \_\_\_\_\_  
\_\_\_\_\_

**Visual History**

1. Has there been previous visual care? **YES / NO** Please describe in detail (include any information about glasses, patching, vision therapy, medication or surgery). \_\_\_\_\_  
\_\_\_\_\_
2. Does your child report or have you noticed any of the following? (Circle one)
 

<u>Yes</u>	<u>No</u>	a. Skipping or rereading words/letters or losing place.
<u>Yes</u>	<u>No</u>	b. Blurred vision during reading or writing.
<u>Yes</u>	<u>No</u>	c. Headaches associated with visual tasks.
<u>Yes</u>	<u>No</u>	d. Complications with print "running together" or "jumping around".
<u>Yes</u>	<u>No</u>	e. Sensation of eyes "not working together".
<u>Yes</u>	<u>No</u>	f. One eye turns in or out, up or down at anytime.
<u>Yes</u>	<u>No</u>	g. Unusual fatigue after visual concentration.
<u>Yes</u>	<u>No</u>	h. Pain or soreness around or in the eyes at anytime.
<u>Yes</u>	<u>No</u>	i. Reddened eyes or lids.
<u>Yes</u>	<u>No</u>	j. Excessive tearing of eyes or rubs eyes frequently.
<u>Yes</u>	<u>No</u>	k. Excessive blinking.
<u>Yes</u>	<u>No</u>	l. Frowning, scowling, or squinting with visual tasks.
<u>Yes</u>	<u>No</u>	m. Tilting or turning head while reading.
<u>Yes</u>	<u>No</u>	n. Closing or covering one eye in bright light or during visual tasks.
<u>Yes</u>	<u>No</u>	o. Moving head forward or backward while looking at a distance object.
<u>Yes</u>	<u>No</u>	p. Loss of concentration or uncomfortable when reading or doing close work.
<u>Yes</u>	<u>No</u>	q. Holding a book too close when reading.
<u>Yes</u>	<u>No</u>	r. Reversals when reading (was-saw, on-no) or writing (b-d, p-q).*
<u>Yes</u>	<u>No</u>	s. Using a finger as a marker when reading.
<u>Yes</u>	<u>No</u>	t. Transposition of letters or numbers (21 for 12).*
<u>Yes</u>	<u>No</u>	u. Poor printing or handwriting.*
<u>Yes</u>	<u>No</u>	v. Difficulty in copying from a whiteboard or screen to paper.*
<u>Yes</u>	<u>No</u>	w. Double vision.
<u>Yes</u>	<u>No</u>	x. Reading slowly or trouble remembering what was read.*

A l e t a B. G o n g • O. D. • P. C. • F. A. A. O. • F. C. O. V. D.

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 Phone (602) 547-3255 • Fax (602) 375-9580 • accenteyes.com

**Visual History continued**

2. Does your child report or have you noticed any of the following? (Circle one)

- |            |           |  |
|------------|-----------|--|
| <u>Yes</u> | <u>No</u> | 1. Confuses similar words.*                            |
| <u>Yes</u> | <u>No</u> | 2. Fails to recognize same word in next sentence.*     |
| <u>Yes</u> | <u>No</u> | 3. Confuses minor likenesses and differences.*         |
| <u>Yes</u> | <u>No</u> | 4. Difficulty following verbal instructions.*          |
| <u>Yes</u> | <u>No</u> | 5. Difficulty completing assignment in time allotted.* |
| <u>Yes</u> | <u>No</u> | 6. Short attention span: distractible.*                |
| <u>Yes</u> | <u>No</u> | 7. Says words aloud or moves lips as reads.*           |
| <u>Yes</u> | <u>No</u> | 8. Poor eye-hand coordination.*                        |
| <u>Yes</u> | <u>No</u> | 9. Repeatedly confuses right left directions.*         |
| <u>Yes</u> | <u>No</u> | 10. Poor recall of visually-presented tasks.*          |

\* May indicate a Visual Information Processing Problem

**Developmental History**

- Were there any complications with pregnancy or at birth? **YES / NO** If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- Was the child born premature? **YES / NO** If yes, what was the length of the pregnancy? \_\_\_\_\_
- Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? **YES / NO**  
If yes, please explain: \_\_\_\_\_
- Were there any developmental delays? **YES / NO** If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- Were there any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, etc.)? **YES / NO** If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**General Health and Behavior**

- Have there been any severe childhood illnesses, high fever, injuries, physical impairment, or ear infections?  
**YES / NO** If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- Has your child ever had a neurological evaluation? **YES / NO** If yes, please indicate the results:  
\_\_\_\_\_
- Does your child have ANY history of epilepsy or seizures? **YES / NO** If yes, please indicate the results:  
\_\_\_\_\_

4. Has your child ever had a speech and language evaluation and/or therapy? **YES / NO** If yes, please indicate when and the results:

\_\_\_\_\_

**General Health and Behavior (continued)**

5. Is your child currently taking medication(s) **YES / NO** If yes, please list medication and purpose :

	<b>Medication</b>	<b>Purpose</b>
<b>1</b>		
<b>2</b>		
<b>3</b>		
<b>4</b>		
<b>5</b>		

6. Has your child ever had a reaction to a medication? **YES / NO** If yes, please describe:

\_\_\_\_\_

7. Does your child have any allergies to food, or environmental allergies? **YES / NO** If yes, please indicate to what and any treatments that the child is receiving: \_\_\_\_\_

\_\_\_\_\_

8. Does your child have frequent periods of extreme fatigue (sluggishness, excitability, irritability) or tensional behavior (nail/tongue/lip biting, eye blinking/rubbing, tantrums)? **YES / NO** If yes, please describe:

\_\_\_\_\_

9. Is there a family history of: Significant reading, writing, or spelling difficulties? **YES / NO**  
Hyperactivity, attention problems, or speech difficulties? **YES / NO**

If yes, who? \_\_\_\_\_

10. What are your child's special interests (sports, hobbies, etc.)?

\_\_\_\_\_

\_\_\_\_\_

**Educational Information**

1. Has your child ever repeated a grade? **YES / NO** If yes, which one(s)? \_\_\_\_\_

2. Has your child ever:  
Had any evaluations (psychological, special education, etc.) **YES / NO**  
Receive any special services from school (speech and language, reading remediation, etc.)? **YES / NO**  
Been in a specialized classroom setting (self-contained, resource, etc.)? **YES / NO**

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

3. In your opinion, what is your child's best subject? \_\_\_\_\_  
hardest subject? \_\_\_\_\_



**Accent Eye Care**  
and Sports Vision Therapy

4. If there is difficulty at school, what do you think is the reason? \_\_\_\_\_

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**Educational Information (continued)**

5. Please indicate **Yes / No** for the following: (Circle one)

- |            |           |  |
|------------|-----------|--|
| <u>Yes</u> | <u>No</u> | Does your child like school?                                       |
| <u>Yes</u> | <u>No</u> | Does your child like his / her teacher?                            |
| <u>Yes</u> | <u>No</u> | Is the school satisfied with the child's performance?              |
| <u>Yes</u> | <u>No</u> | Are you satisfied with the child's school performance?             |
| <u>Yes</u> | <u>No</u> | Does your child attend school on a regular basis?                  |
| <u>Yes</u> | <u>No</u> | Is his / her school performance up to potential?                   |
| <u>Yes</u> | <u>No</u> | Is the child attending the grade level expected for his / her age? |
| <u>Yes</u> | <u>No</u> | Does your child read well as others in the same grade?             |
| <u>Yes</u> | <u>No</u> | Or as well as brother or sisters? (if any)                         |

6. Has the teacher reported anything about your child's school work? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Thank you for carefully completing this questionnaire.**

**Would you like a report? \_\_\_\_\_ To Whom? Please sign at the bottom, giving Accent Eye Care your authorization to send reports to the following:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**I give Aleta B. Gong OD, PC permission to release information to the above people:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_