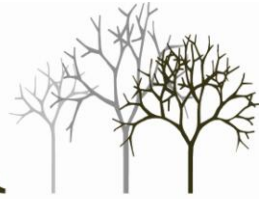


Alderwood



Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a consultation. On the following pages you will find a Vision Questionnaire and symptom checklist. Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the consultation.

IMPORTANT!!!

We MUST have records from your most recent eye exam in order to do a consultation. Please ensure that you have contacted your doctor and that we have received your records before your scheduled appointment time.

Thank you again for your cooperation in providing this complete history.
We look forward to seeing you

16006 Ash Way, Suite 101, Lynnwood, WA 98087
Phone: (425) 787-5200 Fax: (425) 787-5252

Nancy G. Torgerson
Doctor of Optometry

Kristi A. Jensen
Doctor of Optometry

Willow F. Thompson
Doctor of Optometry

DRIVING DIRECTIONS

Alderwood Vision Therapy Center, PLLC
16006 Ash Way, Suite #101
Lynnwood, WA 98087
(425) 787-5200

Southbound on I-5 coming from Everett, WA

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-5 coming from Seattle, WA

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-405

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

From the Edmonds Ferry:

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

Our office is located in a separate building at the north end of Newberry Square.

ADULT STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully.

*Please return it to our office prior to your appointment. **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 _____ Profession: _____

Patient's Full Legal Name: _____ Male Female

Patient's Nickname: _____ Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Email: _____ Marital status: Single Married Divorced Widowed

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone #: _____

Business Address: _____

In Case of Emergency Contact: _____ Phone: _____

INSURANCE

Do you have Vision Insurance? Yes No If yes, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____

Subscriber ID# (incl. letter prefix): _____ Group#: _____

Do you have Medical Insurance? Yes No If yes, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____

Subscriber ID# (incl. letter prefix): _____ Group#: _____

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S)
WITH YOU TO YOUR APPOINTMENT.**

VISION HISTORY

Reason for today's visit: _____

Last Vision examination: _____ Results: _____

Do you wear glasses? Yes No For: constant wear occasional wear near far

Do you wear contact lenses? Yes* No For: full time wear occasional wear

*** For Your Information: We refer out for contact lens fitting, dispensing and follow-up.**

Type: Soft Rigid Gas Permeable

Visual demands: At work (reading, computer, etc.) _____

At play (sports/hobbies) _____

Medications currently taking: _____

For what condition: _____

General health: Good _____ Poor _____

History of eye surgery/LASIK: Yes or No Explain: _____

Allergies: Yes No Specify: _____

Social History:

Do you smoke? Yes No What do you smoke? _____ How many per day? _____

Do you drink? Yes No What do you drink? _____ How much per day? _____

Do you use recreational drugs? Yes No What Drug? _____ How often: _____

List patient's special needs (autistim/developmental delays, etc): _____

List any special concerns: _____

Have you or a family member been treated for any condition related to:

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematological/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			

Specifically is there any family history of:

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia(lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double-vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus(eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date: _____ Dr's Initials: _____

STRABISMUS HISTORY

At what age was it first noticed or suspected that was an eye turning? _____

Did the eye begin turning suddenly or gradually? _____

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 you look:

up close? Yes No

in the distance? Yes No

to your left? Yes No

to your right? Yes No

up? Yes No

down? Yes No

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

PREVIOUS TREATMENTS

Have you had a previous visual evaluation? Yes No

If yes, Doctor's Name: _____ Date of last evaluation: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended or prescribed? Yes ___ No ___

If yes, bifocal? single vision? contact lenses? Other? Explain: _____

Are they worn? Yes No

If yes, when? _____

If no, why not? _____

Does the eye turn less when the prescription is worn? Yes No Unsure

Have you been told that you have amblyopia (lazy eye)? Yes No

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: _____

Has there been any surgical treatment? Yes No

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: _____

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: _____

Has there been any visual therapy? Yes No

If yes, Doctor's name: _____

Date: _____ Dr's Initials: _____

Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: _____

Are you here for a second opinion regarding surgery or other treatment? Yes No

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

Yes

- Eyes ache
- Eyes pull or tug
- Difficulty moving or turning eyes
- Pain with movement of eyes
- Eyes twitch
- Pain in or around eyes
- Eye redness
- Burning eyes
- Watery eyes
- Itchy eyes
- Dry eyes
- Brightness is bothersome
- Motion sickness / car sickness
- Headaches
- Blurred vision at distance
- Blurred vision at near
- Tunnel vision / Loss of visual field
- Flashes of light
- Dizziness
- Double vision
- Frequent Sties

- Head moves when reading
- Lose place often when reading
- Avoid reading or writing
- Words jump or move around when reading
- Short attention span for reading or writing
- Skip words frequently when reading
- One eye turns in, out, up or down
- Movement of objects in the environment is bothersome
- Fluorescent light is bothersome
- Patterned wallpaper or carpets are bothersome
- Objects jump in and out of field of view
- Reduced depth perception
- Loss of interest/concentration when doing close work
- Orient writing/drawing poorly on page
- Squinting, covering or closing one eye
- Head tilts during desk work
- Comprehension decreases the longer you read
- Feels sleepy with reading
- Rubs eyes frequently after/while reading/on computer

- Trouble with spelling
- Often have to re-read a line just read
- Difficulty remembering what is read
- Turns head a great deal with reading or on computer
- Close or cover an eye (right or left)
- Often reverses letters, words, or numbers
- Dislike tasks requiring sustained visual attention
- Feel nervous, irritable, restless, or frustrated after sustained visual concentration
- Lose awareness of surroundings when concentrating
- Blink a lot
- Difficulty using binoculars

- Hold books too close
- Difficulty changing focus far to near
- Discomfort when reading
- Eyes tire quickly when reading, sewing, or on computer
- Distance blurs when looking up from close work
- Vision blurs when concentrating

- Restless when doing desk work
- Eye/body coordination activities (ie dancing) are difficult
- Tailgate when driving
- Eye/hand coordination sports (ie. tennis, baseball) are difficult
- Trouble judging distance when parking/pulling into traffic
- Frequently trip or stumble
- Feel uncomfortable in crowded area with a lot of movement

FINANCIAL POLICY

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide a receipt for reimbursement submission. Copayment is also required at the time of service.

We are participating providers with:

Blue Cross Blue Shield, Regence Blue Shield, Premera Blue Cross, Medicare, and Medicaid/DSHS (**only** open coupon and Regence Healthy Options) **We are not providers with any HMO.**

By signing below you authorize the release of any medical information to process your insurance claim or for the referral to another doctor. You also allow your payment from insurance to be sent directly to Alderwood Vision Therapy Center, PLLC.

Please sign that you understand the above:

Signed: _____ **Date:** _____