

# Alderwood

## Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making a consultation appointment for your child. On the following pages you will find a “Children’s Vision Questionnaire”. Please either return the completed form to our office before your scheduled appointment, or bring it with you to the appointment.

### 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 for your child.  
We look forward to seeing you!

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

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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**

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## **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.**

## CHILDREN'S STRABISMUS QUESTIONNAIRE

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Patient's Name: \_\_\_\_\_  
Patient's Nickname: \_\_\_\_\_

### GENERAL INFORMATION

Were you referred to our office? Yes  No   
If yes, whom may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Profession: \_\_\_\_\_  
Child's Full Legal Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_\_ months  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Name and address of school: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Child's dominant hand (circle): right / left / undetermined?

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	_____
Sibling	_____	Birth Date	_____

### ACCOUNT RESPONSIBLE INFORMATION

Person Responsible for Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Account Responsible Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Father/Caretaker's Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mother/Caretaker's Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
In Case of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have Vision Insurance? Yes  No  If so, who is the carrier? \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group #: \_\_\_\_\_

Do you have Medical Insurance? Yes  No  If so, who is the carrier? \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group #: \_\_\_\_\_

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

**MEDICAL HISTORY**

Pediatrician's Name: \_\_\_\_\_

Child's current state of health: \_\_\_\_\_

Medications currently using, including vitamins and supplements: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

Any allergies to medications? \_\_\_\_\_

List illnesses, bad falls, high fevers, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>

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 your child been diagnosed on the autism spectrum? Yes  No

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 / speech / physical therapy evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has your child or a family member been treated for any condition related to:

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</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	<input type="checkbox"/>	<input type="checkbox"/>	_____

Specifically is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Whom</u>		<u>Patient</u>	<u>Family</u>	<u>Whom</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
"Cross"/"Wall" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other, please explain: \_\_\_\_\_

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

Any history in your family of an eye turn resulting from a disease or other condition? Yes  No

Other health problems? Yes  No

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

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?

Yes  No

If yes, 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? Yes  No

very low energy? Yes  No

Explain: \_\_\_\_\_

### DEVELOPMENTAL 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 at birth: \_\_\_\_\_ After 10 minutes: \_\_\_\_\_

Were forceps used? Yes  No

Was there ever a reason for concern over your child's general growth or development? Yes  No

If yes, why? \_\_\_\_\_

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 your child active? Yes  No

Speech: First words: \_\_\_\_\_ At what age: \_\_\_\_\_

Was early speech clear to others? Yes  No

Is speech clear now? 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? \_\_\_\_\_

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

If not used, why not? \_\_\_\_\_

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

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

At what age did you first notice or suspect 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 urn always present? Yes  No

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) \_\_\_\_\_

Do you notice if the eye turns more when your child is looking:

up close? Yes  No

in the distance? Yes  No

to his/her left? Yes  No

to his/her 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

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

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 ever been told that your child has amblyopia ("lazy eye")? Yes  No

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 operated on, and an estimate of the cosmetic and subjective results: \_\_\_\_\_

Were you satisfied with the results of surgery? Yes  No

Please explain: \_\_\_\_\_

Was the surgeon satisfied with the results of surgery? Yes  No

Please explain: \_\_\_\_\_

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

Has there been any visual therapy? Yes  No

If yes, Drs. name: \_\_\_\_\_

If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: \_\_\_\_\_

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

**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 CHLD REPORT ANY OF THE FOLLOWING:**

	<u>Yes</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	_____

List any other complaints your child makes concerning his/her vision: \_\_\_\_\_

**HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:**

	<u>Yes</u>	<u>If yes, when?</u>
Moves head when reading	<input type="checkbox"/>	_____
Skips, re-reads or omits words	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	_____
Eyes frequently reddened	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	_____
Focus goes in and out	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	_____
Reverses letter or words	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	_____

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

- Vocalizes when reading silently  \_\_\_\_\_
- Confuses right and left  \_\_\_\_\_
- Poor reading comprehension  \_\_\_\_\_
- Comprehension decreases over time  \_\_\_\_\_
- Tires easily  \_\_\_\_\_
- Difficulty recognizing same word on different page  \_\_\_\_\_
- Poor word attack skills  \_\_\_\_\_
- Difficulty with memory  \_\_\_\_\_
- Remembers better what hears than sees  \_\_\_\_\_
- 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  \_\_\_\_\_
- Writes or prints poorly  \_\_\_\_\_
- Writes neatly but slowly  \_\_\_\_\_
- Does not support paper when writing  \_\_\_\_\_
- Awkward or immature pencil grip  \_\_\_\_\_
- Frequent erases  \_\_\_\_\_

**TELEVISION VIEWING/LEISURE TIME ACTIVITIES**

- Does child watch TV? Yes  No
- If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_
- Does your child spend time using computer/video games? Yes  No
- If yes, how much? \_\_\_\_\_ 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
- If yes, which and why? \_\_\_\_\_
- Does your child seem to be under tension or 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: \_\_\_\_\_

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

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 schoolwork is: above average  average  below average

WHICH SUBJECTS ARE:

Above average: \_\_\_\_\_

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? Yes  No

### 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 Parents  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? Yes  No

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 anyone in father's family have a learning problem? Yes  No

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

Date: \_\_\_\_\_ Dr's Initials: \_\_\_\_\_

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 in the family have learning problems? Yes  No

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

To what extent? \_\_\_\_\_

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **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:** \_\_\_\_\_