Welcome to our office and thank you for making an appointment for a vision examination 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.

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

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.

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.:

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 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:

	Patient	Family	Whom		Patient	Family	Whom
Eyes	☐	☐	_____	Neurological	☐	☐	_____
Ears, Nose, Throat	☐	☐	_____	Endocrine Disorder	☐	☐	_____
Cardiovascular health	☐	☐	_____	Genitourinary	☐	☐	_____
Respiratory	☐	☐	_____	Skin	☐	☐	_____
Gastrointestinal health	☐	☐	_____	Musculoskeletal	☐	☐	_____
Psychiatric	☐	☐	_____	Hematological/lymphatic	☐	☐	_____
Allergic/immunologic	☐	☐	_____	Other	☐	☐	_____

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

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

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:

Name	Age	Visual Situation
______________________	____	____
______________________	____	____
______________________	____	____

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:

	Yes	If yes, when?
Headaches	☐	______
Blurred vision	☐	______
Double vision	☐	______
Eyes hurt	☐	______
Eyes tired	☐	______
Words move around on the page	☐	______
Motion sickness / car sickness	☐	______
Dizziness	☐	______
Frequent sties	☐	______

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

____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

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

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:**__________________