WASHINGTON VISION THERAPY CENTER

Last Name: _____First Name:_____Middle Initial:_____ DOB:_____ M or F

Preferred Name:_____ Age: _____ Occupation:_____Marital Status: _____

Address:_____ Home Phone: _____☐ Preferred

City/zip:_____ Cell Phone: _____☐ Preferred

Email: _____ Other Phone: _____☐ Preferred

Emergency Contact:_____ Phone Number:_____

Primary insurance: _____ Secondary Insurance: _____

Family Eye Doctor: _____ Last Eye Exam: _____

Referred By: (Check all that apply)

☐ Family Eye Doctor ☐ Flyer/Mailer ☐ Physical/Occupational Therapist_____

☐ Primary Care Provider ☐ Website ☐ Other Physician_____

☐ Workshop/Lecture ☐ Newspaper ☐ Teacher/School_____

☐ Radio ☐ Patient from our clinic_____ ☐ Staff Member from our clinic_____

Other _____

Medical Information

Primary Care Provider Name:_____ Date of Last Exam:_____

Have you received any of the following examinations? Circle any that apply and write in the name of the provider.

Neuropsychological:_____ Speech/Hearing Specialist:_____

Occupational Therapist:_____ Other Specialist:_____

Results/Recommendations:_____

Born Premature or Complications at Delivery: _____

Formal Diagnosis of (Please circle) ADD / ADHD / or Suspected

Estimated reading ability? (circle) Poor Fair Average Above-Average Excellent

How many hours a day are you on the computer? ____ Hours Reading or Studying? _____

<u>Strabismus/Amblyopia (Wandering/Crossed or Lazy Eyes) – Circle all that apply</u>

Direction of wandering eye? Inward Outward Up Down Which Eye? Right Left Both

At what age did you or others first notice the eye wander? _____

Do you have reduced vision in one eye even after corrected with glasses? Right Eye Left Eye Both Eyes Neither

Have you done patching? Yes / No How long?_____ Kind of patching? Black patch / Eye Drops / Other:_____

At what age were you first diagnosed with Amblyopia (reduced vision in one eye with glasses)?_____

At what age did you start wearing glasses?_____

Name: _____ DOB: _____

Convergence Insufficiency Symptom Survey	Never	Infrequently	Sometimes	Fairly Often	Always
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim or appear to float on the page?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a pulling feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to reread the same line of words when reading?					
Total (Please add up each of the columns)					
Multiply the **Total** by the following	**x0**	**x1**	**x2**	**x3**	**x4**
Subtotal					

Grand Total (Sum of Subtotals) _____ Date Scored: _____

Do you get headaches when reading, doing computer work, or other visual tasks? Yes No (circle all that apply)

Where are they located? Forehead Behind eyes Temples Above Ears Top Back

More one side of the head than another? Right Left Equally both sides

How frequently? _____ How long do they last? _____ How severe on a 1 to 10 scale (10=severe)? ____

Do you take anything or do anything to relieve the headaches? _____

Do your relief strategies work? Yes – resolves headaches Sometimes Never

Head Injury/Stroke/Other Neurological Insult? (Use the back of the final page if you need more space to describe)

Please describe including date of injury and accompanying signs and symptoms: _____

_____

_____

Have you had head imaging? No Yes – Dates and Type:_____

Are you under the care of a physician for the above event? (circle) Yes-Currently Yes-In the Past Never

Were any of the signs or symptoms mentioned above present before this event? No Yes-describe:_____

_____

Is there any other information you feel would be helpful/important in your treatment? _____

_____

Patient's Name: _____ **DOB:**_____ **Date:** _____

Review of Systems

Please mark **each box.** Indicate Yes or No for any current diagnoses or symptoms for the following.
If yes, please describe in the space provided:

☐ **Y** ☐ **N**	General Constitutional (unexplained fever, weight loss or gain, etc.)	_____
☐ **Y** ☐ **N**	Eyes: (Disease related such as Glaucoma, Detached Retina)	_____
☐ **Y** ☐ **N**	Ears, Nose, Throat, Mouth: (hearing loss, chronic nasal congestion, chronic cough)	_____
☐ **Y** ☐ **N**	Respiratory: (asthma, chronic bronchitis, shortness of breath, etc.)	_____
☐ **Y** ☐ **N**	Cardiovascular (diabetes, hypertension, heart problems, etc.)	_____
☐ **Y** ☐ **N**	Gastrointestinal (diarrhea, constipation, hernia, ulcers, etc.)	_____
☐ **Y** ☐ **N**	Genitourinary (painful urination, frequent urination, jaundice, etc.)	_____
☐ **Y** ☐ **N**	Hematological/Lymphatic (anemia, bleeding problems, etc.)	_____
☐ **Y** ☐ **N**	Musculoskeletal (Muscle Pain, trauma, osteoarthritis, osteoporosis, etc.)	_____
☐ **Y** ☐ **N**	Skin (Eczema, Psoriasis, rashes etc.)	_____
☐ **Y** ☐ **N**	Neurological (Epilepsy, Cerebral Palsy, tumor, etc.)	_____
☐ **Y** ☐ **N**	Psychiatric (ADHD, Depression, anxiety, etc.)	_____
☐ **Y** ☐ **N**	Endocrine (Diabetes, Thyroid problem, etc.)	_____
☐ **Y** ☐ **N**	Allergic/Immunological **(Please list all food, environmental, and medication allergies)**	

_____

Personal Medical History

Please List all current medications:

1. _____ for _____ 2. _____ for _____
3. _____ for _____ 4. _____ for _____

Does the patient have any of the following illnesses or conditions (Please circle and describe in the space below):

None

Autism	**ADHD**	**Dyslexia or other reading problems**	**Developmental Delays**	**Lupus**
High Blood Pressure	**Heart Disease**	**Thyroid Disease**	**Diabetes**	**Cancer**

Description of Above or other:_____

Patient's Name: _____ DOB:_____

Does the patient have any of the following eye conditions (Please circle and describe in the space below):
Blindness, Cataracts, Macular Degeneration, Glaucoma, Retinal Detachment, Strabismus, Amblyopia

None	**Blindness**	**Cataracts**	**Macular Degeneration**
Glaucoma	**Retinal Detachment**	**Strabismus**	**Amblyopia**

Description of Above or other:_____

Family Medical History

Mark **Each box** Yes or No to indicate of any member of your family has had these diseases. Family history includes your parents, grandparents, siblings, and your children.

		Relationship to Patient			Relationship to Patient
☐ **Y** ☐ **N**	Blindness		☐ **Y** ☐ **N**	High Blood Pressure	
☐ **Y** ☐ **N**	Cataract		☐ **Y** ☐ **N**	Heart Disease	
☐ **Y** ☐ **N**	Macular Degeneration		☐ **Y** ☐ **N**	Thyroid Disease	
☐ **Y** ☐ **N**	Glaucoma		☐ **Y** ☐ **N**	Diabetes	
☐ **Y** ☐ **N**	Retinal Detachment		☐ **Y** ☐ **N**	Cancer Type:	
☐ **Y** ☐ **N**	Lupus		☐ **Y** ☐ **N**	Other:	

☐ **Y** ☐ **N** Strabismus (eye turn or crossed eyes) _____

☐ **Y** ☐ **N** Amblyopia (Lazy Eye) _____

☐ **Y** ☐ **N** Dyslexia (or other reading problems) _____

Social History

Please answer the following questions (for young children you can select N/A):

Do you currently or have you in the past used tobacco products? ☐ **Y** ☐ **N** ☐ **N/A**
If yes, please describe the types of tobacco products, the amount of use, and if you are no longer using them, what year you quit using them.

_____

_____

Please describe your alcohol consumption (how many days per week you drink and how many drinks you have in an average week)? ☐ **N/A**

_____

_____

If you use them, please describe your use of Recreational/Street drugs (How long you have taken them, what type, the amount taken, and the frequency of taking them)? ☐ **N/A**

Female: Are you pregnant? ☐ **Y** ☐ **N** ☐ **N/A** If yes, how many months pregnant are you?_____

Name: _____ DOB: _____ Date: _____

10-Point Scaled Symptom Survey

On a scale from 0-10 (10 being most severe) how severe are the following symptoms while doing visual tasks?

		Score:	Comments:
1	Headaches (In general including frequency and severity)		
2	Eye strain, soreness, pain, or discomfort		
3	Eyes get tired and generally become tired		
4	Double vision, shadowing of letters, words move, jump, swim, appear to float on the page		
5	Blurry Vision even though glasses are on or have been told glasses are unnecessary		
6	Loss of place, skipping words and/or lines while reading, or have to reread the same line of words		
7	Motor Coordination/Difficulties with Depth perception (accident prone, poor hand-eye coordination, avoid or have poor performance in sports, frequently knock things over, trip, fall, or run into things, poor rhythm/timing)		
8	Academic Concerns (Poor Interest in reading and school, poor reading comprehension, poor grades, homework takes longer than it should, poor handwriting)		
9	Visual Perceptual Difficulties (Letter reversals, confusion with words, letters, numbers, symbols, get lost in details, fatigues or becomes confused with too much info on page, confused with different fonts, poor visual recall)		
10	Balance/Dizziness/Vertigo/Disorientation/Nausea?		
11	Poor attention, focus, concentration, hyperactivity?		
12	Brain fog, sensory overstimulation, motor overload (Unable to think clearly with too much stimulus, overwhelmed with too much light, sound, busy visual environments/patterns, unable to sit still or reflexive movements due to overstimulation)		
13	Behavior problems, poor self-esteem/confidence, easily frustrated, anxiety, depression		
14	Eye wanders or crosses?		
15	Other - please describe: (difficulty with multitasking, auditory processing difficulties, etc.)		

Visual Signs/Symptoms Checklist Name: _____ DOB: _____

READING AND WORK

- ☐ Decreased Reading Speed
- ☐ Decreased Reading Comprehension
- ☐ Short attention span with reading
- ☐ Avoid reading
- ☐ Poor performance at work
- ☐ Evening reading/computer work is strenuous
- ☐ Takes longer than normal to read/do work
- ☐ Difficulty focusing between near and far
- ☐ Difficulty reading words/signs at a distance
- ☐ Loses place when reading often
- ☐ Struggled when you were in school
- ☐ Cover an eye when reading

SPORTS, COORDINATION

- ☐ Accident Prone
- ☐ Poor Coordination
- ☐ Poor Balance
- ☐ Dislikes sports/physical activities
- ☐ Poor performance in sports/physical activities
- ☐ Poor Rhythm and timing
- ☐ Poor depth perception

VISUAL PERCEPTION

Visual Discrimination

- ☐ Difficulty seeing the difference between two similar letters, shapes, or objects
- ☐ With math, omits/confuses steps or function signs (+, -, x, ÷, <, >)
- ☐ Reverses Letters/Words
- ☐ Confuses words

Visual Figure-Ground

- ☐ Difficulty finding a specific piece of information on a page or in a situation
- ☐ Difficulty with getting “lost in the details”
- ☐ Easily frustrated or fatigues quickly with too much print on a page

Visual-Motor Processing Issues

- ☐ Difficulty with visually guided motor activities
- ☐ Poor handwriting
- ☐ Difficulty writing within the lines or margins
- ☐ Difficulty copying from a book or a whiteboard
- ☐ Frequently drops utensils or knocks over drinks

Form Constancy Issues

- ☐ Difficulty recognizing letters, words, or numbers, especially if the size, font, or color changes
- ☐ Confuses lefts and rights
- ☐ Difficulty recognizing the same objects in different situations.
- ☐ Difficulty recognizing letters, words, or numbers, especially if presented differently (ie paper, book, or board)
- ☐ Difficulty building or putting together something from a set of instructions

Visual Closure

- ☐ Difficulty identifying an object when only parts are visible (example: truck but missing wheels, or a person if missing facial features)

Visual-Spatial Issues

- ☐ Difficulty telling where objects are in space
- ☐ Difficulty with depth perception or judging how far things are from them and from each other
- ☐ Poor balance or coordination
- ☐ Difficulty with crowding when writing
- ☐ Difficulty with telling time, reading maps, and/or judging time
- ☐ Often trip, falls, or bumps into things
- ☐ Prone to getting lost

Long- or Short-Term Visual Memory Issues

- ☐ Difficulty recalling what has been seen
- ☐ Difficulty with recognizing familiar words either recently or from page-to-page
- ☐ Difficulty with spelling familiar words or words they have practiced many times
- ☐ Difficulty remembering what they have read
- ☐ Difficulty using a keyboard or calculator

Visual Sequencing Issues

- ☐ Difficulty telling the order of symbols, words or images
- ☐ Difficulty in writing answers on a separate sheet
- ☐ Difficulty remembering sequences, step-by-step instructions, or understanding concept of “first, next, last”

RELEASE OF INFORMATION:

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I, _____ give WASHINGTON VISION THERAPY CENTER, permission to release any Protected Health Care Information regarding my medical records, including diagnosis to other health care professionals, specifically, but not limited to those listed below, when it is necessary for the treatment of my visual condition.

_____ Primary Care Physician/Clinic

_____ Other Physician/Clinic

_____ Primary Eye Doctor/Clinic

_____ Spouse/Significant Other

Signatures:

_____ Patient Signature

_____ Date

Expires on: ☐ End of Treatment (OR)

☐ _____ Specific Date

****

INSURANCE – ONLY AN ESTIMATE:

Washington Vision Therapy Center is willing to provide you with an ESTIMATE of what your insurance will or will not cover. However, we cannot and do not guarantee that the ESTIMATE we provide is correct. When we as the provider or you call in to get the ESTIMATE it is given with the statement "this is not a guarantee of payment". Please understand that while we will assist you in understanding your benefits, we have no influence over your coverage. You are ultimately responsible for all fees and charges on your account.

I understand that payment in full is due at time of service unless other arrangements have been made.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I also give permission for Washington Vision Therapy Center to release any Medical Records requested by my insurance company for claim processing. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Thank you,

I have read and accept this policy,

Patient name (Printed): _____

Signature of Patient: _____ Date: _____

Statement of Privacy Practices
Washington Vision Therapy Center

303 South 72nd Ave.
Yakima, WA 98908
Phone 509.654.9256

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend your privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our vision and medical care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone that you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality vision and medical care, implement payment activities, conduct normal optometric practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history and health records. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for third party marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments, including voice mail messages, answering machines, postcards, and email.

Patient Rights
You have the right to request copies of your healthcare information and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

HIPAA Privacy Practice Acknowledgment:
I have received or was offered and declined a notice of privacy practices.

Patient Name (Printed): _____

Signature of Patient: _____ Date: _____

Name: _____ DOB: _____ Date: _____