WASHINGTON
VISION THERAPY
CENTER

Last Name: ______________________ First Name: __________ Middle Initial: _______ DOB: ___________ M or F

Preferred Name: ________________ Age:(years) _____ (months) ______ Grade: _______ School: _________________

Mother/Guardian Name: ________________________________ Occupation: __________________________________

Father/Guardian Name: ________________________________ Occupation: __________________________________

☐ Married ☐ Divorced/Separated – Child living with: ____

Address: ______________________________________ Home Phone: ____________________ ☐ Preferred

City/zip: ______________________________________ Cell Phone: _____________________ ☐ Preferred

Email: _________________________________ Other Phone: ____________________ ☐ Preferred

Non-Guardian Emergency Contact: _________________ Phone Number: ____________________

Primary insurance: _____________________________ Secondary Insurance: ________________________

Family Eye Doctor: ______________________ Last Eye Exam Date: ______________

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

Pediatrician's Name: _____________________________ Date of Last Exam: ________________

Does the Pediatrician have any areas of concern regarding the child's health?

____

Has your child 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: ____

History of Head Injury/Stroke/Other Neurological Insult: ____

Born Premature or Complications at Delivery: ____

Developmental History — Please Explain Below

☐ **Y** ☐ **N** Delays in **gross** motor development (i.e. difficulties learning to ride a bike, catch a ball, play sports, etc.)? ______________________________

☐ **Y** ☐ **N** Delays in **fine** motor development (i.e. difficulties learning to use scissors, tie shoes, draw/write, etc.)? ______________________________ ______________________________

☐ **Y** ☐ **N** Delays in learning to crawl or walk? (please note if child skipped crawling) ______________________________ ______________________________

☐ **Y** ☐ **N** Other Developmental Delays ______________________________

Name: ________________ DOB:___________

Convergence Insufficiency Symptom Survey **(Please fill this out with your child)**	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: ______________

Did your child repeat a grade or have a delayed start? ☐ **Y** ☐ **N** Explain: ______________________________

____

Has your child received special tutoring or remedial assistance? ☐ **Y** ☐ **N** Explain: ______________________

____

Do you have any concerns about your child's behavior? ☐ **Y** ☐ **N** Explain: ______________________________

____

Has your child ever had a head injury/stroke/Other Neurological Insult? ? ☐ **Y** ☐ **N** Explain: ____________

____

Is your child performing up to their potential? ________________

Is there any other information you feel would be helpful/important in our treatment of your child?_______________

____

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

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? _______

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

Patching? Yes / No How long?_______ Kind of patching? Black patch / Eye Drops / Other:________

At what age was your child first diagnosed with Amblyopia (reduced vision in one eye with glasses)?_____

At what age did your child start wearing glasses?_____

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 Child			Relationship to Child
☐ **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?__________

Patient lives with: (please circle) **Both Parents** **Single Parent** **Guardian**

Who else lives at home with the child: (please circle) **Siblings** **Others:** __________________________

Number of children at home **:**____ Is the patient exposed to second hand smoke?: **Y or N**

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)
- ☐ Difficulty with spelling or reading because they can’t recognize a word if a letter is missing

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 YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I, ______________________________ Parent of ______________________________ give WASHINGTON VISION THERAPY CENTER, permission to release any Protected Health Care Information regarding his/her medical records, including diagnosis to my child's school and/or other health care professionals, specifically, but not limited to those listed below, when it is necessary for the treatment of my child's visual condition.

______________________________ Primary Care Physician/Clinic

______________________________ Other Doctor/Clinic

______________________________ Primary Eye Doctor/Clinic

______________________________ School District

______________________________ Other Family Member: (Relationship)

______________________________ Other Family Member: (Relationship)

Signatures:

______________________________ Parent's or Guardian's Signature

______________________________ Date

______________________________ RELATIONSHIP TO PATIENT

Expires on: ☐ End of Treatment (OR)

☐ ____________________ Specific Date

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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 or my dependents.

Thank you,

I have read and accept this policy,
Patient name (Printed):______________________________

Responsible party name (Printed): ______________________________

Signature of Parent/Guardian: ______________________________ 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 Parent/Guardian: ______________________________________ Date: ______________________

Relationship to Patient: ____