



## KINDERGARTEN/1<sup>st</sup> GRADE VISION QUESTIONNAIRE

*Please fill out this questionnaire carefully and return it to our office prior to the evaluation such that I am ready to examine your child. **THANK YOU.***

Patient's Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_\_ months

### RESPONSIBLE PERSON INFORMATION

**Please note that payment is expected on the day of the evaluation (check or cash).** A fee slip will be given that can be submitted for insurance reimbursement depending on the particulars of your health insurance plan.

Parent/Caretaker: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Parent/Caretaker: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Parent/Caretaker's Occupation: \_\_\_\_\_ Business and/or cell Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent/Caretaker's Occupation: \_\_\_\_\_ Business and/or cell Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list the names and birth dates of your family:

Sibling: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Sibling: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Sibling: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name and address of child's school: \_\_\_\_\_  
Grade: \_\_\_\_\_ Child's dominant hand (circle): right or left?

### 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? \_\_\_\_\_

### 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? \_\_\_\_\_

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

Members of the family who have had visual problems:

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

**Have you or anyone else** ever noticed the following regarding your child?

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
An eye turns in or out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reddened or encrusted eyelids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes in constant motion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyelids droop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stares at bright lights or repeatedly flicks objects in front of face	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is abnormally bothered by bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems visually unaware	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head to one side	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has a tendency to rub eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stumbles over objects or is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor motor control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks interest in looking at objects or seeing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to see distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does **your child** verbalize any problems/complaints about his/her eyes or vision? Yes  No

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

**Please include copies of all the tests and evaluations that have been completed:**

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 educational/ neuropsychological testing been performed? Yes  No   
By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has an occupational therapy, physical therapy or speech/language evaluation been performed?  
Yes  No  By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

**MEDICAL HISTORY**

Pediatrician's Name: \_\_\_\_\_ Date of Last Evaluation: \_\_\_\_\_

Diagnoses and recommendations: \_\_\_\_\_

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

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

Immunizations child has received and dates:

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Any reactions to immunization(s)? Yes  No  If yes, explain: \_\_\_\_\_

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 had any head traumas or accidents? Please describe \_\_\_\_\_

\_\_\_\_\_

Is there any known history of the following?

	<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	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<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"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
"Cross" or "Wall" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issues	<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"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<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: \_\_\_\_\_

Any learning problems in the family? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Adopted: Yes  No  Age when adopted \_\_\_\_\_ Country of origin \_\_\_\_\_

Does the child know that he/she was adopted? Yes  No

Full-term pregnancy? Yes  No

Did the birth mother experience any health problems during the pregnancy? Yes  No

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

Any complications before, during or immediately following delivery? Yes  No

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

Birth weight: \_\_\_\_\_ Apgar scores @ birth: \_\_\_\_\_ After 10 minutes: \_\_\_\_\_

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes  No

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

Any problems with colic? Yes  No

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 child active? Yes  No

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

Was early speech clear to others? Yes  No

Is speech clear now? Yes  No

How many hours daily does your child sleep? \_\_\_\_\_

Does your child sleep through the night? Yes  No  If yes, starting at what age: \_\_\_\_\_

If no, explain: \_\_\_\_\_

What percent of the waking hours is/was your child in a playpen? \_\_\_\_\_

In a walker? \_\_\_\_\_

In a seat? \_\_\_\_\_

What things can your child do very well? \_\_\_\_\_

What things, if any, are difficult for your child? \_\_\_\_\_

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

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

Has your child received any special developmental guidance/assistance? Yes  No

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

### NUTRITIONAL INFORMATION

Are there any food allergies/sensitivities? Yes  No

If yes, what: \_\_\_\_\_

Was your child nursed?  Until what age: \_\_\_\_\_ Bottle fed?  Until what age? \_\_\_\_\_

Solid food started at what age: \_\_\_\_\_ What type? \_\_\_\_\_

Activity Level: High  Moderate  Low

Are there periods of very high energy? Yes  No

Are there periods of very low energy? Yes  No

Does your child: Like sweets  and/or Crave sweets

If so, what? \_\_\_\_\_

What are his/her favorite foods? \_\_\_\_\_  
What foods does he/she dislike/avoid? \_\_\_\_\_

**SCHOOL**

Name of Teacher (s): \_\_\_\_\_

Age at time of entrance to school: \_\_\_\_\_

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 like school? Yes  No

Does your child like the teacher(s)? Yes  No

Compared to other children his/her age, do his/her general performance and social skills seem to be above  equal to  or below

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

Which school activities are easy for your child? \_\_\_\_\_

Which school activities are difficult for your child? \_\_\_\_\_

Specifically describe any school difficulties: \_\_\_\_\_

Does your child seem to be under tension at school? Yes  No

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

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes  No

If yes, when? \_\_\_\_\_

Where and from whom? \_\_\_\_\_

**TELEVISION/COMPUTER/TABLET/SMART PHONE VIEWING**

Does your child watch TV? \_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

Does your child spend time using computer/tablet/smart phone/video games? Yes  No

If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

What activities does your child do on his/her/your smart phone? \_\_\_\_\_  
Watch videos?  Play games?

**CURRENT ABILITIES/BEHAVIOR**

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes  No  If yes, which? \_\_\_\_\_

Can your child identify numbers or letters? Yes  No  If yes, which? \_\_\_\_\_

Does your child like to draw/color? Yes  No

Is your child learning to read? Yes  No

How is your child performing as compared to others his/her age:

Above average  Below average

How well developed is your child's spoken vocabulary? \_\_\_\_\_

How well does your child understand/respond to spoken language? \_\_\_\_\_

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity  Irritable, easily upset

Thumb-sucking  Restlessness

Nervous  Has difficulty separating from parents

Glum, sulky, moody  Sleeplessness

Temper concerns  Lethargic, low energy

Passive  Aggressive

Other (please explain): \_\_\_\_\_

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

How does your child get along with:

Parents/other caretakers? \_\_\_\_\_ Siblings? \_\_\_\_\_

Classmates in school? \_\_\_\_\_ Playmates at home? \_\_\_\_\_

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: \_\_\_\_\_

## **GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:**

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Is there any other information that would be helpful/important in our evaluation or treatment of your child? \_\_\_\_\_

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Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day/7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Celia Hinrichs".

Celia Hinrichs, O.D., FCOVD

**Please print and sign the next page – Permission to Treat and Release of information**



**Celia Hinrichs, O.D., FCOVD**

169 Powers Road  
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**Permission to Treat and Release of information**

**PERMISSION TO TREAT**

I hereby give my permission to Dr. Celia Hinrichs to treat \_\_\_\_\_  
(Child's Name)

\_\_\_\_\_  
Parent's or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF PROTECTED HEALTH INFORMATION**

It is often beneficial for 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 the release of this information.

I agree to permit protected health information from, or copies of, the medical records of my child, \_\_\_\_\_, to be exchanged with (1) my child's school yes / no (please circle one); (2) other health care providers yes / no (please circle one); or provided to insurance carriers upon their written request or upon the recommendation of Celia Hinrichs, O.D., FCOVD, when it is necessary for the treatment of my child's visual condition or for the processing of insurance claims. This authorization shall be valid for the duration of my treatment.

I understand that I can change my mind and cancel this permission at any time by writing a letter to CAH Vision and sending or bringing it to 169 Powers Road, Sudbury, MA 01776. If the information has already been exchanged or given out, I understand that it is too late for me to change my mind and cancel the permission.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Relationship to Patient