VISION
Be the vision you wish to see

CELIA HINRICHS, O.D., FCOVD

TEENAGE VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office before the evaluation such that I am ready to examine you. 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 this problem/difficulty a result of a work-related accident? _____
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:

Name	Age	Visual Situation

Have **you or anyone else** ever noticed the following:

	Yes	No	If yes, when and who noticed?
Headaches	☐	☐	
Blurred vision/focus goes in and out	☐	☐	
Double vision	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Words move around on the page	☐	☐	
Motion sickness/car sickness	☐	☐	
Dizziness	☐	☐	
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye	☐	☐	
Difficulty seeing distant objects	☐	☐	
Head close to paper when reading or writing	☐	☐	
Avoids reading	☐	☐	
Prefers being read to	☐	☐	
Tilts head when reading	☐	☐	
Tilts head when writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letter or words	☐	☐	
Reverses letter or words	☐	☐	
Confuses right and left	☐	☐	
Skips, rereads or omits words	☐	☐	
Loses place while reading	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Tires easily	☐	☐	
Difficulty copying from chalkboard	☐	☐	

	Yes	No	If yes, when and who noticed?
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	☐	☐	

Please include reports 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 an occupational therapy, physical therapy or speech/language evaluation been performed?
Yes ☐ No ☐ By whom? _____ Results and recommendations: _____

Has educational/ neuropsychological testing been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
Diagnoses and recommendations: _____
Your current state of health: _____
Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

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

Age	Severe	Mild	Complications

Have you had any head traumas or accidents? Please describe _____

Are there any chronic problems like colds, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____

_____

Current diet restrictions and/or concerns: _____

_____

Is there any known history of the following?

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

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

If other, please explain: _____

_____

DEVELOPMENTAL HISTORY:
Adopted: Yes ☐ No ☐ age when adopted_____ country of origin_____
Does the teenager 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: _____
Was there ever any reason for concern over general growth or development?
Yes ☐ No ☐.
If yes, why? _____

TELEVISION/COMPUTER/TABLET/SMART PHONE VIEWING/LEISURE TIME ACTIVITIES
Do you watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Do you spend time using computer/tablet/smart phone/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What activities do you do on your smart phone? _____
Watch videos? ☐ Texting? ☐ Write papers? ☐
What other activities occupy your leisure time? _____
Are there any activities you would like to participate in, but don't? ___
Please explain: _____

_____

SCHOOL

Do you like school? Yes ☐ No ☐

Specifically describe any school difficulties: _____

_____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? _____

Do you seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐

Have you had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐

If yes, when? _____

Where and from whom? _____

Do you like to read? Yes ☐ No ☐

Voluntarily? Yes ☐ No ☐

Do you read for pleasure? Yes ☐ No ☐

What? _____

What is your attitude toward reading, school, your teachers, peers? _____

_____

Overall schoolwork is: above average ☐ average ☐ below average ☐

Which subjects are:

Above average: _____

Average: _____

Below average: _____

Do you need to spend a lot of time/effort to maintain this level of performance?

Yes ☐ No ☐

How much time on average do you spend each day on homework assignments? _____

To what extent do you get assistance with homework? _____

Do you feel you are achieving up to your potential? Yes ☐ No ☐

Do you think your teachers feel you are achieving up to your potential? Yes ☐ No ☐

FAMILY AND HOME

Please indicate which adult(s) you live with? Mother ☐ Father ☐ Stepmother ☐

Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐

Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____

Do you spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: _____

How do you get along with:

Parents/other caretakers? _____ Siblings? _____

Classmates in school? _____

Any learning problems in the family? .. _____

_____

Have you ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐

If yes, at what age: _____

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: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR TEENAGER?

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 on 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 visual status.

THANK YOU.

Celia Hinrichs, O.D., F.C.O.V.D.

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

Celia Hinrichs, O.D., FCOVD
169 Powers Road
Sudbury, MA 01776
(978) 443-7529
Fax (978) 405-3194
office@CAHVision.com

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