RISING STAR OPTOMETRY &
VISION ACADEMY OPTOMETRY

GENERAL INFORMATION

Patient's Name: _____ Gender: _____

Date of Birth: _____ Age: _____ Grade: _____

Parent/Guardian: _____ Occupation: _____

Address: _____

Parent/Guardian: _____ Occupation: _____

Address: _____

Best Phone #: (____) _____ Alternate Phone #: (____) _____

Fax: (____) _____ email: _____

Copy of our evaluation to your <u>referral source</u>? Yes / No

Referral Source: _____ Phone #: (____) _____

Referral Source Address: _____

Copy of our evaluation to your <u>teacher</u>? Yes / No

Teacher: _____

School: _____ Phone #: (____) _____

School Address: _____

Copy of our evaluation to your <u>pediatrician</u>? Yes / No

Pediatrician: _____ Phone #:(____) _____

Pediatrician Address:_____

DEVELOPMENTAL HISTORY RISING STAR OPTOMETRY & VISION ACADEMY OPTOMETRY

Child's Name _____ Birthday _____/_____/_____ Age _____ Yr _____ Mo _____

Grade _____ School's Name and Address _____ Teacher's Name: _____

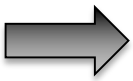
Parent/Guardian's Name _____ Occupation _____Phone _____

Parent/Guardian's Name _____ Occupation _____ Phone _____

Mailing Address _____

Who referred you to this clinic? _____ Number of Children in Family _____

I. Please state the major reason(s) you would like your child examined:



_____

II. Vision	Yes	No	Comments
Headaches			
Blurred Distance Vision			
Blurred Reading Vision			
Holds Books Closer than Normal			
Eyes Hurt			
Eyes Tire			
Eye Turn (crossed or wall-eyed)			
Blinks Excessively			
Covers One Eye While Doing Homework			

III. School	Yes	No	Comments
Is your child having problems in school?			
Does your child like the teacher?			
Is school satisfied with child's performance?			
Are you satisfied with child's performance?			
Do grades really show his/her ability?			
Is there trouble completing written assignments?			
Does your child lose his/her place while reading?			
Does your child misread words that are known?			

IV. Behaviors: Please rate your child: (Place a number in the blank space to the left of the item)

1- Always 2- Frequently 3- Occasionally 4- Rarely 5- Never 6- Unknown

_____ Hyperactive	_____ Poor Ability to Organize Work	_____ Confusion Following Verbal Instructions
_____ Easily Distracted	_____ Indistinct Speech	_____ Variable School Performance, hour to hour
_____ Short Attention Span	_____ Awkward or Clumsy	_____ Reverse letters, words, or numbers in reading
_____ Easily Frustrated	_____ Poor Peer Group Relationships	_____ Reverse letters, words, or number's in writing
_____ Impulsive	_____ Behavioral Problems	_____ Show Confusion about Right and Left
_____ Easily Fatigued	_____ Emotional Problems	_____ Show confusion about directional orientation

V. Physical Development: At what age in years and months did your child:

Speak words clearly _____ Start to crawl _____ Walk unaided _____

Which Phrase describes the child's physical maturity (please circle number)?

1-Physically **Immature** for age **2**-**Average** physical maturity for age **3**-**Advanced** physical maturity

VI. School Progress: Rate your child's progress in the following subjects: **(1= below, 2= grade level, 3= above)**

_____Reading _____Spelling _____Writing _____Arithmetic _____Art _____PE _____Other? _____

What Specific type(s) of work is your child having difficulty with? _____
_____

Have other family members had difficulties learning any of the above subjects? No _____ Yes _____

If yes, state relationship to child and subjects: _____

Does your child have memory difficulties? No _____ Yes _____ If so, what type of information? _____

_____

VII. General History: Is there a history of pregnancy or birth complications? No _____ Yes _____

If yes, please explain: _____

Has there been any severe childhood illness, high fever, injury or physical impairment? No _____ Yes _____

If yes, please explain: _____

Has your child received a hearing test? No _____ Yes _____ Date _____/_____/_____

Has a hearing or speech deficiency been diagnosed? No _____ Yes _____

If yes, please explain: _____

Has your child had any ear infections in the past (Y/N)? ___ If yes, how many? ___ Both ears (Y/N)? ___ Tubes (Y/N)? ____

Has your child received a complete eye examination? No _____ Yes _____ Date ____/____/____ Drops used (Y/N)? _____

Has a visual problem been diagnosed?_____

Does your child have any allergies? No _____ Yes _____ If yes, to what? _____

Is your child currently taking any medications or pills? No _____ Yes _____If yes, please list the medications, their purpose, and duration: _____

_____

Has your child previously taken medication for hyperactivity? No _____ Yes _____

VIII. Therapy: Has there been any previous therapy for learning difficulties or visual or speech problems? No ___ Yes ___

If yes, please state the type of therapy, duration, and results: _____

_____

VIIII. Family Eye History:_____

Signature: _____Date: _____/_____/_____

Relationship to child: _____ Comments: _____

Physician Signature: _____Date: _____/_____/_____

CONSENT FOR TREATMENT

RISING STAR OPTOMETRY & VISION ACADEMY OPTOMETRY

PATIENT'S NAME: _____

I voluntarily give my permission to the healthcare providers of Rising Star Optometry ("RSO") and Vision Academy Optometry ("VAO") and such assistants and other health care providers, as they may deem necessary to provide medical services to me/my child. I understand by signing this form, I am authorizing them to treat me/treat my child as long as I seek care from RSO and VAO.

Patient/Parent/Guardian Initials: _____

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided my representatives of RSO and VAO. I understand that RSO and VAO are not contracted with insurance carriers and that **payment is due in full at the time of visit**. RSO and VAO will make every effort to provide you with an insurance superbill that may be submitted to your insurance carrier for reimbursement. I understand that this does not guarantee I will be reimbursed for these medical services provided by RSO and VAO.

Patient/Parent/Guardian Initials: _____

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received the Notice of Privacy Practices from RSO and VAO. I also understand that information contained in this form and collected during my examination may be used for teaching purposes or statistical analysis.

Patient/Parent/Guardian Initials: _____

Consent to Communicate Via Email- Email is not HIPAA Compliant

I voluntarily give my permission to RSO and VAO to Communicate with me or my child via Email. This communication could include but is not limited to: appointment reminders, spectacle/contact lens prescriptions and notifications (by request), and exam reports, letters, or evaluations. I give this permission understanding that e-mail may be unencrypted and therefore is not secure. E-mail contents and attachments may be read by unintended recipients.

Circle one:

YES I give permission to communicate using this email address:

_____

NO I do NOT want any communication to occur via e-mail.

Patient/Parent/Guardian:

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

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Visual Skills Symptom Survey

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Instructions: read the *Subject Instructions* and then each item exactly as written. Name:_____ Age:_____
If subject responds with "yes" – please qualify with frequency choices. Do not give examples. Today's Date:_____

Subject Instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

		Never (0)	Infrequently (1)	Sometimes (2)	Fairly Often (3)	Always (4)
1	Do your eyes feel tired when reading or doing close work?					
2	Do your eyes feel uncomfortable when reading or doing close work?					
3	Do you have headaches when reading or doing close work?					
4	Do you feel sleepy when reading or doing close work?					
5	Do you lose concentration when reading or doing close work?					
6	Do you have trouble remembering what you have read?					
7	Do you have double vision when reading or doing close work?					
8	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9	Do you feel like you read slowly?					
10	Do your eyes ever hurt when reading or doing close work?					
11	Do your eyes ever feel sore when reading or doing close work?					
12	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14	Do you lose your place when reading or doing close work?					
15	Do you have to re-read the same line of words when reading?					

Add up total number of points. Consider referral for a Visual Efficiency Exam if total score is 16 or higher for kids, 22 for adults.

TOTAL SCORE: _____

Adapted From: Convergence Insufficiency Symptom Survey---V15 from Borsting EJ, Rouse MW, Mitchell GL, Cotter SA et al. (2003) Validity and reliability of the revised convergence insufficiency symptom survey in children aged 9 to 18 years. Optom Vis Sci 80:832=-838.