TEXAS VISION THERAPY

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CHILDREN'S INTAKE FORM

Child's Name: _____ ☐ Male ☐ Female
Birth Date: _____ Age: _____ years _____ months
Reason for Visit: _____
Were you referred to our office? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _____
Phone: _____
Address: _____
Email Address: _____
If not referred, how did you learn about our office? _____
_____

Please list the names and birth dates of your family:
Father/Caretaker: _____ Birth Date: _____
Mother/Caretaker: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____

Name and address of school: _____
_____
Grade: _____Teacher: _____ School Nurse: _____
Social Worker: _____ Principal: _____

RESPONSIBLE PERSON INFORMATION:
Home Address: _____
City: _____ Zip: _____
Home Phone: _____ Mother Cell #: _____
Father Cell # _____
Father's Occupation: _____ Place of Employment: _____
Business Phone: _____ Email Address: _____
Mother's Occupation: _____ Place of Employment: _____
Business Phone: _____ Email Address: _____

PATIENT'S MEDICAL HISTORY:

Pediatrician's Name: _____Phone Number: _____

Medications currently using, including vitamins and supplements:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____

Allergies to foods or medications. If yes, please list: _____

_____

Please list any illnesses, bad falls, high fevers or ear infections, 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 a neurological evaluation been performed? ☐ Yes ☐ No

If yes, by whom? _____

Results and recommendations: _____

Has a psychological evaluation been performed? ☐ Yes ☐ No

If yes, by whom? _____

Results and recommendations: _____

Has an occupational therapy evaluation been performed? ☐ Yes ☐ No

If yes, by whom? _____

Results and recommendations: _____

Has a speech therapy evaluation been performed? ☐ Yes ☐ No

If yes, by whom? _____

Results and recommendations: _____

Has your child been evaluated by any other medical specialist? ☐ Yes ☐ No

If yes, by whom? _____

Results and recommendations: _____

PATIENT'S MEDICAL HISTORY, continued

Please mark an "X" on conditions that apply

_____ Strabismus (Crossed Eyes)
_____ Amblyopia (Poor Vision)
_____ Learning Disability
_____ Dyslexia
_____ ADD/ADHD
_____ Asperger's Syndrome/Autism
_____ Other, please list_____

_____ Epilepsy/Seizure
_____ Chromosomal Imbalance
_____ Diabetes
_____ Thyroid Condition
_____ Brain Tumor/Brain Injury/Concussion

FAMILY MEDICAL HISTORY

Please mark an "X" on all applicable conditions and list the family member(s) with them?

_____ High Cholesterol - Family Member(s): _____
_____ Thyroid - Family Member(s): _____
_____ Heart Disease - Family Member(s): _____
_____ Cancer - Family Member(s): _____
_____ Diabetes - Family Member(s): _____
_____ High Blood Pressure - Family Member(s): _____
_____ Glaucoma - Family Member(s): _____
_____ Cataracts - Family Member(s): _____
_____ Macular Degeneration – Family Member(s): _____
_____ Retinal Detachment - Family Member(s): _____
_____ Strabismus (Crossed Eyes) - Family Member(s): _____
_____ Amblyopia (Poor Vision) - Family Member(s): _____
_____ Other - Family Member(s): _____

OCULAR 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: _____

Wears glasses, contact lenses, or other optical devices recommended? ☐ Yes ☐ No

If yes, what type? _____

Are they used? ☐ Yes ☐ No If yes, when? _____

If not used, why not? _____

DEVELOPMENTAL HISTORY:

Was the pregnancy full term? ☐ Yes ☐ No

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

If yes, please list: _____

Did the mother smoke, drink alcohol, use legal or illegal drugs? ☐ Yes ☐ No

If yes, please list: _____

Were there any complications before, during or immediately following delivery? ☐ Yes ☐ No

If yes, please list: _____

Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____

Was there ever any reason for concern over your child's general growth or development?

If yes, please list: _____

DEVELOPMENTAL MILESTONES:

Please list the age your child was able to complete the following tasks:

Age	Task
_____	Crawl on stomach on the floor
_____	Crawl on all fours
_____	Walk
_____	First words

Was speech clear to others? ☐ Yes ☐ No

Is speech clear now? ☐ Yes ☐ No

GENERAL BEHAVIOR:

Are there any behavior problems (play groups, play dates)? ☐ Yes ☐ No

If yes, what? _____

Are there any behavior problems at home? ☐ Yes ☐ No

If yes, what? _____

What causes these problems? _____

_____

_____

How does your child react to fatigue? ☐ sad ☐ irritable ☐ other

How does your child react to tension? ☐ avoidance ☐ irritable ☐ other

Does your child say and/or do things impulsively? ☐ Yes ☐ No

Is your child in constant motion? ☐ Yes ☐ No

SCHOOL:

At what age did your child begin school: Pre-school: _____ Kindergarten: _____

Does your child like school? ☐ Yes ☐ No

Does your child like their teacher? ☐ Yes ☐ No

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

If yes, when? _____

Where and from whom? _____

How long? _____

Results: _____

Does your child like to read? ☐ Yes ☐ No

Does your child like to be read to? ☐ Yes ☐ No

Does your child follow along while reading together? ☐ Yes ☐ No

Does your child engage with the pictures? ☐ Yes ☐ No

ELECTRONIC USE/LEISURE TIME ACTIVITIES:

How much time does your child spend on electronics outside of school? Avg per day_____

How much time does your child spend outside? Avg per day_____

FAMILY AND HOME:

Please indicate which adult(s) he/she lives with? ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

☐ Other Caretaker (please specify): _____

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 to this situation? ☐ Yes ☐ No

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

_____

_____

_____

_____

_____

_____

DOES YOUR CHILD EVER REPORT ANY OF THE FOLLOWING?

Symptom	Yes	No	If yes, when, and how often?
Headaches	☐	☐	
Blurred vision / focus goes in-out	☐	☐	
Words move on the page	☐	☐	
Doubled vision	☐	☐	
Eyes hurt	☐	☐	
Eyes are tired	☐	☐	
Motion sickness / car sickness	☐	☐	
Dizziness	☐	☐	

Have you, or anyone else you know, ever noticed the following in your child?

Symptom	Yes	No	If yes, when, and how often?
Eyes frequently red	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Frequent closing / covering 1 eye	☐	☐	
Eyes deviate, eyes turn in or out	☐	☐	
Does the child squint?	☐	☐	
Difficulty seeing distant objects	☐	☐	
Difficulty seeing near objects	☐	☐	
Head close to paper with near work	☐	☐	
Dislikes / avoids reading	☐	☐	
Tilts head when reading / writing	☐	☐	
Moves head when reading	☐	☐	
Confuses right and left	☐	☐	
Confuses letters or words	☐	☐	
Reverses letters or words	☐	☐	
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	☐	☐	
Difficulty copying from board	☐	☐	
Difficulty recognizing same words on a different page	☐	☐	
Poor word attack skills	☐	☐	
Difficulty with memory	☐	☐	
Remembers better what they hear than what they see	☐	☐	
Seems to know material, but does poorly on tests	☐	☐	
Poor sequencing	☐	☐	
Writes or prints poorly	☐	☐	
Writes neat, but slowly	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequently erases / deletes	☐	☐	
Dislikes / avoids near tasks	☐	☐	
Avoids making eye contact	☐	☐	
Difficulty following instructions	☐	☐	
Short attention span / loses interest	☐	☐	
Tires easily	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with small hand tools / scissors	☐	☐	
Dislikes / avoids sports	☐	☐	
Difficulty catching / hitting a ball	☐	☐	
Clumsy, tends to fall often	☐	☐	
Poor balance	☐	☐	
Uncomfortable in new places	☐	☐	

PAYMENT POLICY / HIPAA

Examination and procedure fees are due at the time of service and as we are not contracted with any insurance panels, we will not submit this to your medical insurance. We will give you the appropriate coding to seek reimbursement yourself directly, though. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE. THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST. I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Texas Vision Therapy. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "NO-SHOW", "NO-CALL" OR MISSED APPOINTMENT WITHOUT PROPER 24-HOUR NOTIFICATION, WILL BE CHARGED A $200 FEE. We do not schedule the types of exams that you find in routine eyecare offices; as such, we cannot easily fill that missed appointments with a walk-in. Please respect our scheduling. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms. Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your specific visual needs.

If you have any questions, please contact our office at (832)-684-9833 prior to your appointment.

Signature of Responsible Party _____ Date _____