The Center for Vision Development & Performance Vision Therapy

The following information will help prepare your child for the upcoming appointment at our office. Your timely completion of these forms will allow us the needed time to process and review your case in advance. We ask that every page be filled out in its entirety and all pertinent medical records including the most recent eye exam are returned to our office **at least two business days prior to the scheduled evaluation**.

What is a Developmental Vision Evaluation?

A Developmental Vision Evaluation includes checking the general health of the eye, visual acuity (20/20), refractive condition for appropriate corrective lenses when needed and all of the visual functions required for reading, writing, learning, sports performance and functioning in life. A developmental vision evaluation helps to pinpoint the precise area(s) of concern as well as the depth of the problem and to determine the best treatment options.

What tests are performed?

Sensorimotor Testing- measures ocular motility, ocular alignment, and ocular deviation in more than one area of gaze and binocular fusion. It is necessary for detection, assessment, monitoring and guidance for the medical, surgical and optical management of binocular function and motor eye misalignment.

Visual Perceptual Testing- tests the brain's ability to make sense of what the eyes see. It is important for everyday activities such as dressing, eating, writing, and playing. When a child is behind in the development of visual processing skills, learning can take longer, requiring more cognitive effort that slows down the learning process.

How long does the testing take?

Testing takes approximately 2 hours and is scheduled in the morning before the eyes and brain are tired from a full day of school. We also like to do testing at this time so your child has eaten a good, high protein meal and is most attentive. We try our best to fully engage your child and to make it as fun as possible.

Who can come to the appointment?

Because full attention is needed, it is very important that you **do not bring any additional family members such as siblings to the evaluation**. We ask that only the patient and parents. This minimizes distraction and enhances the productivity of the time spent in our office.

What is my financial policy?

Third-parties, such as medical insurance, Medicare and TennCare, severely limit treatment, care options, and the time the Doctor and team can spend with you. Therefore, The Center for Vision Development and Performance Vision Therapy are a fee-for-service facility and payment is due in full at the time of service. The total cost of the Initial Visit is $275, which includes the evaluation, testing, consultation, and a follow-up summary of the Doctor's findings.

Will I get the results the same day?

Yes! During your consultation all of the findings will be explained to you and literature will be provided. The recommendations from the Doctor, how to proceed and expectations will also be explained.

We look forward to meeting you and your child! If you have any additional questions, please feel free to contact us at:

The Center for Vision Development
400 Sugartree Ln., Ste. 310
615-791-5766
info@thecenterforvision.com

Performance Vision Therapy
3252 Aspen Grove Dr., Ste. 12
615-905-4668
info@tnperformancevision.com

Kindergarten-High School
History Form

Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.

Patient's Full Name:_____ Nickname:_____

Date of Birth:_____ Age: _____ Gender: Male or Female

Address:_____ City:_____ Zip:_____

Cell:_____ Email:_____

Name of School:_____ Grade: _____

HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business _____

Internet: Which terms did you search? Vision Therapy Lazy Eye Crossed Eye ADHD Learning Disabilities Convergence Autism Tracking Issues Reading Issues

Current/Previous Patient: _____

CONTACT INFORMATION

Mother/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

Father/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

YOUR CHILD'S MEDICAL HISTORY: *Please fully complete*

Pediatrician: _____ Date of Last Visit: _____

Practice Name: _____

Phone Number: _____ Fax Number: _____

Current Medications (include vitamins/supplements): _____

_____

Is your child allergic to any medications? If yes, please list or circle **No Know Drug Allergies**

_____

List any major illnesses or injuries: _____

Did your child receive all of their recommended immunizations? Yes or No

Immunizations not received: _____

Kindergarten-High School
History Form

Review of Systems	List diagnosis, surgeries, or hospitalization for your child
Constitutional Symptoms (e.g. fever, weight loss)	
Hematologic (e.g. anemia)	
Allergic/Immunologic	
Endocrine	
Psychiatric	
Neurological	
Cardiovascular	
Respiratory	
Ears, Nose, Mouth, or Throat	
Gastrointestinal	
Skin Disorders	
Musculoskeletal	
Genitourinary	
Other	

If your child has been professionally diagnosed with any of the following, please circle

ADHD	Autism Spectrum	Disruptive Behavior	Intellectual Disability
Anxiety	Down Syndrome	Executive Functioning	Speech Delay
PTSD	Non-Verbal	Sensory Processing	Mental Retardation
Bipolar	Dyscalculia	Obsessive Compulsive Disorder	Chromosomal Issues
Depression	Dysgraphia	Oppositional Defiant Disorder	Genetic Disorder
Self-Harm	Dyslexia	Conduct Disorder	Cognitive Impairment
Suicidal	Dyspraxia	Auditory Processing	Developmental Delay
Apraxia	Dysorthography	Expressive Language	Receptive Language
Tourette's	Cerebral Palsy	Reading Comprehension Deficit	Learning Disability

Additional Comments: _____

_____

_____

Kindergarten-High School
History Form

YOUR CHILD'S VISUAL HISTORY

Has your child's vision ever been evaluated? Yes or No *If yes, please fully complete:*

Optometrist/Ophthalmologist: _____ Last Visit: _____

Practice Name: _____

Results and Recommendations: _____

Does your child wear (circle): Glasses Contacts Both

Any problems with current prescription? _____

Why do you feel your child needs an evaluation for vision therapy? _____

_____

Has the patient ever had vision therapy? □ No □ Yes, Doctor's name and city:

_____

Is there any evidence from the school, psychological tests, or other tests that indicate some visual issue may be present? *Yes* or *No* If yes, what? _____

YOUR CHILD'S DEVELOPMENTAL HISTORY

Is the patient adopted or foster child? □ Yes □ No At what age? _____ From? _____

Do you know prior medical history? □ Yes ☒ No Is the patient a multiple? □ No □ Yes

Full-term pregnancy? □Yes □No Explain: _____

Birth Weight:_____ Apgar Scores: at birth_____ after 10 minutes:_____

Any pregnancy/delivery complications? Please explain: _____

_____

Did your child crawl (on stomach)? Yes or No At what age?_____

Did your child creep (on all fours)? Yes or No At what age?_____

Age they started: walking _____ said first word _____

Was early speech clear to others? Yes or No Is speech clear now? Yes or No

---

Your Child's School and Reading Habits

Age at time of entrance to: Pre-school: ____ Kindergarten: _____ Current School Grade: ____

Is your child homeschooled? Yes or No If yes, by whom? _____

Do you belong to a homeschooled group? If yes, name: _____

Does your child attend public or private school? Yes or No Did he/she graduate? Yes or No

School Name:_____ Teacher's Name:_____

Kindergarten-High School
History Form

Has your child changed schools often? Yes or No If “yes”, when & why? _____

_____

Has a grade been repeated? Yes or No If “yes”, which and why?_____

_____

Does your child like school? Yes or No

If yes, what parts? _____

In no, why not? _____

Does the patient currently have an Individualized Education Plan (IEP)? □ Yes □ No

If yes, explain accommodations: _____

_____

Does the patient currently have a 504 Plan or receive intervention at school? □ Yes □ No

If yes, explain accommodations: _____

_____

Has the patient had any special tutoring or remedial assistance? □ Yes □ No

Name of tutor/assistant: _____ How long? _____

Facility Name: _____

What were the results: _____

Which subjects are:

Above average: _____

Average: _____

Below average:_____

Does your child like to read? Yes or No Does your child read voluntarily? Yes or No

Is a lot of time/effort spent on maintaining this level of performance? □ No □ Yes

How much time on average is spent each day on homework assignments? _____hours

To what extent does the patient need assistance with homework? _____

_____

Do you and/or the teacher feel the patient is achieving up to potential? □ Yes □ No

Explain: _____

Kindergarten-High School
History Form

Have any of the following evaluations been performed?

ABA evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Tester Name & Title: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Psychological evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Tester Name & Title: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Educational evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Tester Name & Title: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Occupational Therapy evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Speech Therapy evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Physical Therapy evaluation? □ Yes □ No Currently in treatment? □ Yes □ No
Therapist Name: _____ Phone: _____
Facility Name & Address: _____
Results and recommendations:_____

Your Child's Screen and Leisure Time Activities

Average screen time per day (TV, tablets, computers, phones, etc.):_____

What other leisure activities do you/your child do? _____

Are there activities you/your child would like to participate in, but don't? Yes or No

Please explain: _____

Kindergarten-High School
History Form

Your Child's Family and Home

Are there others living in your home? □ No □ Yes Please list names, ages, and relation below:

_____

_____

_____

Does your child spend a significant amount of time with any other person not in the home?
Please explain: _____

Has your child ever been through a traumatic family situation (separation, divorce, parental loss, separation from parents, severe parental illness, etc.)? Yes or No
If yes, at what age? _____ Does your child seem to be adjusted? Yes or No
Please explain: _____

_____

Was therapy/counseling undertaken? Yes or No If yes, is it on-going? Yes or No
Therapist & Facility Name: _____ Phone: _____
Is family stable currently? Yes or No If no, please explain: _____

FAMILY HISTORY ***(Please check if there is any history of the following.)***

	N	Y	Family Member		N	Y	Family Member
Poor Vision/ High Rx/Myopia				High Blood Pressure			
Strabismus/Eye Turn				Epilepsy or Seizures			
Amblyopia (lazy eye)				Diabetes			
Blindness				Thyroid			
Glaucoma				Cancer			

Kindergarten-High School
History Form

SLEEP HABITS

How many hours of sleep does the patient get each night? _____ What time do you/you child go to bed? _____ Does your child sleep through the night? □ Yes □ No

Does the patient use any sleep aids? □ No □ Yes, please list: _____

Has the patient ever been diagnosed with and/or treated for sleep apnea? □ Yes □ No

Age at diagnosis? _____ Does your child use CPAP/BiPAP? □ Yes □ No

Has the patient ever experienced bedwetting? □ Yes □ No Is it ongoing? □ Yes □ No

---

Give a brief description of your child as a person:_____

_____

_____

What are your biggest concerns regarding your child at this time?_____

_____

_____

What is your goal for your child's visual evaluation and/or vision therapy? _____

_____

_____

I hereby give my permission to The Center for Vision Development and Performance Vision Therapy to treat:

_____

Patient's Name

_____ _____

Patient, Parent, or Guardian's Signature Date

Kindergarten-High School
History Form

Release of information:
It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your child's care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to myself or my child's other health care providers upon their written request or upon recommendation of The Center for Vision Development and Performance Vision Therapy when it is necessary for the treatment of my child's visual condition. I authorize The Center for Vision Development, Performance Vision Therapy, and their staff to exchange information with other professionals involved in my child's care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
Signature Date

_____
Relationship to patient

Release of Information to Non-Medical Staff/Family Members

I, _____, give permission for The Center for Vision Development and/or Performance Vision Therapy to release medical information to the following non-medical individual(s). (Family members (do not include parents/legal guardians), teachers, tutors, coaches)

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

_____ _____
Signature Date

_____
Relationship to patient

Kindergarten-High School
History Form

Patient Photo and Video Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information.

This release is strictly designed to give permission to The Center for Vision Development and Performance Vision Therapy, to use my digital patient photos and/or video for their website, social media, and in office presentation for both educational and promotional purposes. Our providers and staff will have permission to use these photos in the manner discussed with me, unless I request the office no longer use them. I understand that by allowing The Center for Vision Development and Performance Vision Therapy to use my photos, I am expressing consent to share images publicly to educate and explain procedures and results of therapy. I understand that I have the option to decline this request and am not obligated in any way to provide permission to use these photos.

Please check appropriate box:

- ☐ I will allow The Center for Vision Development and Performance Vision Therapy to share my digital patient photos, recorded videos and my written success story/testimonial
- ☐ I am requesting that none of my information be shared publicly

Patient Name: _____

Printed Parent Name: _____

Signature: _____ Date:_____

Office Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physician and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time with your new patient paperwork completed. As a courtesy, and to help patients remember their scheduled appointments, we send a confirmation email after scheduling and a reminder call a few days prior to your appointment. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

Kindergarten-High School History Form

COVD Lifestyle Checklist

After you consider each question, mark the column that applies to the person you are assessing.

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS	SCORE
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is “I can’t” before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
					TOTAL SCORE	