1605 ROCK PRAIRIE ROAD SUITE 214
COLLEGE STATION, TX 77845
979.541.APEX (2739)
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CHILDREN'S EXTENDED QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office the Friday prior to your appointment. THANK YOU.

Appointment: Day: _____ Date _____ Time _____

Patient's Name: _____

CHILD INFORMATION

Child's Full Name: _____ Gender: ☐ Male ☐ Female

Birth Date: _____ Age: _____years _____months Is your child especially afraid of doctors? ☐ Yes ☐ No

Child's dominant hand: Right ☐ or Left ☐? Has guidance been given in use of hand? ☐ Yes ☐ No

Mom's Cell: _____ Mom's Email:_____

Dad's Cell: _____ Dad's Email:_____

Address: _____

Referral Information

How did you hear about us? _____

If you were referred, whom may we thank for this referral? _____

Phone: _____

Address: _____

Please list any individuals who you would like a report sent:

Name	Business Name	Address	Phone

VISUAL HISTORY

Current Visual Symptoms

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed? _____

Are You here for a second opinion regarding surgery or further treatment? ☐ Yes ☐ No

If therapy is recommended, what are your goals? _____

_____

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Child Complaints

Does your child complain of or do you or anyone else continue to notice the following:

Indicate yes or no and how often: 0=Never, 1=Seldom, 2= Occasionally 3 = Frequently, 4= Always

Refractive Status and Focusing Symptoms	**Yes**	**No**	**Unsure**	**How Often? (0 = Never, 4= Always)**				
Blurred distance vision	☐	☐	☐	0	1	2	3	4
Blurred near vision	☐	☐	☐	0	1	2	3	4
Vision worse at end of day	☐	☐	☐	0	1	2	3	4
Headaches	☐	☐	☐	0	1	2	3	4
Eyes “hurt” or “tired”	☐	☐	☐	0	1	2	3	4
Avoids reading or other near tasks	☐	☐	☐	0	1	2	3	4
Lag in focus	☐	☐	☐	0	1	2	3	4

Ocular Motility Symptoms	**Yes**	**No**	**Unsure**	**How Often? (0 = Never, 4= Always)**				
Moves head when reading	☐	☐	☐	0	1	2	3	4
Skips, omits words	☐	☐	☐	0	1	2	3	4
Loses place when reading	☐	☐	☐	0	1	2	3	4
Uses finger as marker	☐	☐	☐	0	1	2	3	4

Eye Teaming (Binocularity) Symptoms	**Yes**	**No**	**Unsure**	**How Often? (0 = Never, 4= Always)**				
Closes or covers an eye	☐	☐	☐	0	1	2	3	4
Tilts head	☐	☐	☐	0	1	2	3	4
Reads slowly	☐	☐	☐	0	1	2	3	4
Double vision	☐	☐	☐	0	1	2	3	4
Words move around on the page	☐	☐	☐	0	1	2	3	4
Words run together when reading	☐	☐	☐	0	1	2	3	4
Car or motion sickness	☐	☐	☐	0	1	2	3	4
Poor reading comprehension	☐	☐	☐	0	1	2	3	4

Eye-Hand Coordination Symptoms	**Yes**	**No**	**Unsure**	**How Often? (0 = Never, 4= Always)**				
Poor / awkward large motor coordination	☐	☐	☐	0	1	2	3	4
Poor / awkward fine motor coordination	☐	☐	☐	0	1	2	3	4
Clumsy, knocks things over	☐	☐	☐	0	1	2	3	4
Poor/inconsistent in sports	☐	☐	☐	0	1	2	3	4

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	Yes	No	Unsure	How Often? (0 = Never, 4= Always)				
Knows material, but does poor on tests	☐	☐	☐	0	1	2	3	4
Writes poorly or slowly	☐	☐	☐	0	1	2	3	4
Difficulty copying from the chalkboard	☐	☐	☐	0	1	2	3	4
Misaligns digits in a column of numbers	☐	☐	☐	0	1	2	3	4
Writing slants up or downhill	☐	☐	☐	0	1	2	3	4
Cannot stay on or between ruled lines	☐	☐	☐	0	1	2	3	4

Visual Perception Symptoms	Yes	No	Unsure	How Often? (0 = Never, 4= Always)				
Confuses right or left	☐	☐	☐	0	1	2	3	4
Confuses letters and words	☐	☐	☐	0	1	2	3	4
Reverses letters or words	☐	☐	☐	0	1	2	3	4
Forgetful/poor memory	☐	☐	☐	0	1	2	3	4
Trouble following directions	☐	☐	☐	0	1	2	3	4
Difficulty recognizing same word on different page	☐	☐	☐	0	1	2	3	4
Misplaces belongings	☐	☐	☐	0	1	2	3	4
Can't spell known sight words	☐	☐	☐	0	1	2	3	4
Difficulty attending to details	☐	☐	☐	0	1	2	3	4
Vocalizes when reading silently	☐	☐	☐	0	1	2	3	4

Other Visual Symptoms	Yes	No	Unsure	How Often? (0 = Never, 4= Always)				
Says "I can't" before trying	☐	☐	☐	0	1	2	3	4
Difficulty completing tasks on time	☐	☐	☐	0	1	2	3	4
Bothered by light	☐	☐	☐	0	1	2	3	4
Dizziness	☐	☐	☐	0	1	2	3	4

List any other complaints your child continues to make concerning his/her vision: _____

_____

Do you feel your child's vision continue to hinder his/her daily activities in any way? ☐ Yes ☐ No

If yes, how? _____

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PREVIOUSLY DIAGNOSED EYE CONDITIONS

	Patient	Family	Who
Amblyopia (Lazy Eye)	☐	☐	_____
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Diabetic Eye Disease	☐	☐	_____
Eye Injury	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Disease	☐	☐	_____
Retinal Disease	☐	☐	_____
Strabismus (Eye Turn)	☐	☐	_____
Other	_____		

Parent Observations of Eye Turn (if applicable)

Which eye turns? ☐ Right ☐ Left ☐ Both ☐ Unsure

Direction: Does the eye turn (check all that apply): ☐ in ☐ out ☐ up ☐ down

At what age did you first notice the eye turn? _____

Onset: Did the eye begin turning ☐ suddenly ☐ gradually

Context: Is the eye turn getting ☐ worse ☐ better ☐ no change

Under what conditions is it present? (i.e. when tired, when ill, etc.):

_____

Did it result from disease, trauma or related condition? ☐ Yes ☐ No If yes, elaborate:

_____

_____

EVALUATION HISTORY

Has your child had a previous visual evaluation? ☐ Yes ☐ No Date of Last Visit: _____

Doctor's Name: _____Practice Name: _____

Practice Phone Number: _____

Results and recommendations: _____

_____

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TREATMENT HISTORY

Eyewear History

Were glasses, contact lenses, patches, eye surgery, vision therapy or atropine ever prescribed? ☐ Yes ☐ No

If yes, what type? ☐ Bifocal ☐ Single-vision ☐ Contact lenses ☐ Other: _____

When are they worn, or if not, why not? _____

_____

Surgical History (if applicable):

Surgeon's Name: _____ Practice Name: _____

Practice Phone Number: _____

Were you satisfied with the results of the surgery? ☐ Yes ☐ No Why? _____

Was the surgeon satisfied with the results? ☐ Yes ☐ No Why? _____

Vision Therapy/Patching History

Doctor's Name: _____ Practice Name: _____

Practice Phone Number: _____

Were you satisfied with the patching results? ☐ Yes ☐ No Why? _____

Were you satisfied with the therapy results? ☐ Yes ☐ No Why? _____

MEDICAL HISTORY

Pediatrician's Name: _____ Name of Practice: _____

Phone: _____

Date of Last Evaluation: _____ Reason: _____

Results and recommendations: _____

_____

Is your child generally healthy? Yes ☐ No ☐ If no, explain: _____

_____

Medications and Supplements

Medication	Condition Treated by Medication
_____	_____
_____	_____
_____	_____

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Allergies: _____

Please describe any concussions, bad falls, high fevers, traumatic events etc. and resulting complications:

Age	Event	Complication

PREVIOUSLY DIAGNOSED MEDICAL CONDITIONS:

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who
ADHD	☐	☐	_____
Brain Tumor	☐	☐	_____
Genetic Condition	☐	☐	_____
Diabetes	☐	☐	_____
Dyslexia	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
High blood pressure	☐	☐	_____
Learning Disability	☐	☐	_____
Thyroid Condition	☐	☐	_____
Tubes in ears	☐	☐	_____

Other (What Condition and Who Had It): _____

SPECIALIST HISTORY (Check off if your child ever received any of the following types of evaluations.)

Type of Evaluation	Specialist Name	Facility Name	Phone	Results/Recommendations
☐ Neurological				
☐ Psychological				
☐ Occupational therapy				
☐ Physical Therapy				
☐ Speech/hearing				
☐ Educational				

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DEVELOPMENTAL HISTORY

Other Development Concerns: Please explain any developmental concerns: _____

_____

ACADEMIC HISTORY

School Information

Name of school: _____ Grade: _____

Address:_____

Teacher: _____ School Nurse: _____Principal: _____

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____

Does your child like school? ☐ Yes ☐ No

Specifically describe any school difficulties: _____

_____

Has your child changed schools often? ☐ Yes ☐ No If yes, when and why? _____

Has a grade been repeated? ☐ Yes ☐ No If yes, which and why? _____

Does your child seem to be under tension or extreme pressure when doing school work? ☐ Yes ☐ No

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

If yes, what kind of assistance? _____

Where and from whom? _____

How long? _____

What were the results? _____

Does your child like to read? ☐ Yes ☐ No What? _____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____

_____

Overall schoolwork is: ☐ Above average ☐ Average ☐ Below average

Which subjects are?

Above average: _____

Average: _____

Below average: _____

Does your child need to spend a lot of time/effort to maintain this level of performance? ☐ Yes ☐ No

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

Does the teacher feel your child is achieving up to potential? ☐ Yes ☐ No

How much time on average does your child spend each day on homework assignments? _____

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To what extent do you assist your child with homework? _____

_____

DIGITAL DEVICE AND LEISURE TIME ACTIVITIES

How many hours per day of TV does you child watch? _____

How many hours per day does your child use a computer/ game? _____

What other activities occupy your child's leisure time? _____

Are there any activities your child would like to participate in, but doesn't? ☐ Yes ☐ No

If yes, explain: _____

GENERAL BEHAVIOR

Are there any behavior problems at school? ..... ☐ Yes ☐ No

Explain: _____

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

Explain: _____

Child's reaction to fatigue? _____

Child's reaction to tension? _____

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

Is your child in constant motion? ☐ Yes ☐ No

Can your child sit still for long periods? ☐ Yes ☐ No

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FAMILY AND HOME

Family Information

Who does the child live with? Check all that apply.

☐ Mom ☐ Dad ☐ Step-Mom ☐ Step-Dad ☐ Grandma ☐ Grandpa

☐ Siblings ☐ Aunt ☐ Uncle ☐ Adopted Parents ☐ Foster Care

☐ Other: _____

Please list the names, relation, age, and quality of relationship your child has with your family.

Name	Relation	Age	Quality of Relationship
_____	**Parent/Sibling/Other**	_____	☐ Great ☐ Average ☐ Strained
_____	**Parent/Sibling/Other**	_____	☐ Great ☐ Average ☐ Strained
_____	**Parent/Sibling/Other**	_____	☐ Great ☐ Average ☐ Strained
_____	**Parent/Sibling/Other**	_____	☐ Great ☐ Average ☐ Strained
_____	**Parent/Sibling/Other**	_____	☐ Great ☐ Average ☐ Strained

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)?

☐ Yes ☐ No If yes, explain: _____

Does your child seem to have adjusted? ☐ Yes ☐ No

Was counseling/therapy undertaken? ☐ Yes ☐ No If yes, is it ongoing? ☐ Yes ☐ No

Is family life stable at this time? ☐ Yes ☐ No If no, please explain: _____

_____

Please give a brief description of your child as a person:

_____

_____

_____

_____

Is there any other information that would be important/useful in our treatment of your child?

_____

_____

_____

_____

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RELEASE OF INFORMATION

It is often beneficial to us to discuss examination results and to exchange information with your child's school, pediatrician, and/or other professionals involved in his/her 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 other health care providers or insurance carriers upon their written request or upon the recommendation of Apex Performance Vision when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Lisa Januskey, OD and Apex Performance Vision to exchange information with my child's school and 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.

_____ _____
Parent's or Guardian's Signature Date

_____
Parent's Printed Name

I hereby give my permission to the Apex Performance Vision to treat: _____.
(Child's Name)

_____ _____
Parent's or Guardian's Signature Date

_____
Parent's Printed Name

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Thank You!

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to better understand and meet your child's specific visual needs. **This questionnaire must be submitted by the Friday before your appointment or your visit will be cancelled.** It is important for our doctor to review your questionnaire prior to your appointment to be able to follow up with additional questions during your appointment time.

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. **Failure to submit the questionnaire before the deadline or provide 24 hours notice of cancellation will result in the forfeit of your deposit.**

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status. Failure to arrive on time may prevent the doctor from being able to complete the evaluation. **Additional appointment slots needed to complete the evaluation will result in additional fees.**

Please make sure that your child is well rested and fed before the appointment. Leave anything or anyone that you feel may distract your child at home so that we can have your child's undivided attention during the evaluation.

THANK YOU.

Sincerely,

Dr. Lisa Januskey, OD

Dr. Lisa Januskey, OD
Developmental Optometrist