**Phone: (770) 904-0979**

Website: www.visiontherapy4kids.com
Email: PVDCvisiontherapy@gmail.com

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**FORSYTH LOCATION:**

2920 Ronald Reagan Blvd. #104
Cumming, GA 30041
Fax: 470-297-3854

**GWINNETT LOCATION:**

2055 Hamilton Creek Pkwy #120
Dacula, GA 30019
Fax: 470-655-7914

**WELCOME TO PEDIATRIC VISION DEVELOPMENT CENTER**
We look forward to meeting you at your appointment.

**WHAT TO EXPECT AT YOUR APPOINTMENT:**
Dr. Rouw and/or Dr. Shadeed will work directly with you during your evaluation which may include testing of the following visual skills: Eye Movement Control, Simultaneous Focus at Far, Sustaining Focus at Far, Simultaneous Focus at Near, Sustaining Focus at Near, Simultaneous Alignment at Far, Sustaining Alignment at Far, Simultaneous Alignment at Near, Sustaining Alignment at Near, Central Vision (Visual Acuity), Prescription for glasses, Peripheral Vision, Depth Awareness, Color Perception, Gross Visual-Motor, Fine Visual-Motor, Visual Perception, and Visual Integration.

**FEES and PAYMENTS**: The Pediatric Vision Development Center is not a provider for insurance plans and does not submit claims to insurances. **ALL FEES FOR VISION THERAPY APPOINTMENT ARE DUE AT THE TIME OF THE SERVICE AND IS THE RESPONSIBILITY OF THE PATIENT/PARENT(S)/GUARDIAN(S).** Our office will be happy to write a Letter of Medical Necessity and provide invoices for your visits that may be helpful when you are submitting your claim in order for you to receive reimbursement from your insurance provider. It is against our office policy to receive payment from your insurance company.

**CANCELLED OR MISSED APPOINTMENTS:** Please understand that each appointment time is dedicated to you and is therefore not available to anyone else. We understand emergencies occur, please notify us as soon as possible if you are unable to keep your appointment. If you have not cancelled your appointment and do not show, you are making this appointment time unavailable for others.

**There is a $35.00 Fee for Not Showing for your appointment and/or Cancellations within 24 hours.**

I understand that if I cancel or no-show for 2 consecutive appointments, I will be subject to removal from the schedule including all future appointments at Pediatric Vision Development Center's discretion.

Signature__________________________________________ Date_________________________________

# Neuro-Optometric Rehabilitation Medical History Form

Name__________________________________________ Date ________________________ Date of Birth______/______/_____
Month Day Year

Mailing address_____________________________________________________________________________________
Street City State Zip Code

Contact Number: Hm__________________________Cell ___________________________ Email:____________________________

**EYECARE DOCTOR:**________________________________________________________ Date of Exam________/______/____
Name of Eyecare doctor Month Day Year

Location of Eye Exam ___________________________________________________________________________________
Name of Practice /Address Phone

**MEDICAL DOCTOR:**________________________________________________________ Date of Exam_____/_______/_____
Name of Medical doctor Month Day Year

Location of Medical Exam_________________________________________________________________________________
Name of Practice /Address Phone

How did you hear about us? □Friend □Internet □Optometrist □Rehabilitation therapist □Physician □Other_______________

**REFERRAL INFORMATION:** The results of the testing will be sent to the referring professional.

You are referred by ________________________________________ Reason for Referral ______________________________

Address_________________________________________________________________Phone Number________________________

**INFORMATION RELEASE**: If you would like information sent to any addition person, please provide the following:

________________________________________________________________________________________________________
Name Address City/ State Zip Phone Fax

Profession Type □ Primary Care Physician □ Rehabilitation therapist □ Optometrist □ Other ________________

________________________________________________________________________________________________________
Name Address City/ State Zip Phone Fax

Profession Type □ Primary Care Physician □ Rehabilitation therapist □ Optometrist □ Other ________________

**GENERAL HEALTH MEDICAL HISTORY**

List ALL Allergies to Medications and/or Foods ___________________________________________________________

List ALL Medications currently taking _________________________________________________________________

List ALL therapies taken including dates (vestibular, occupational, physical, speech)___________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

**TYPE OF INJURY**

Yes □ No □ Stroke/Date(s)________________________________________________________________________________

Yes □ No □ Other/Date(s)_________________________________________________________________________________

Yes □ No □ Concussion/Date(s) _________________ If yes: Sports/Activity at time of Concussion___________________

Location of impact? ____________________________________________________________________________________

Symptoms noted at time of injury: □loss of vision □double vision □loss of consciousness □dizziness □vomiting □other (please explain) _____________________________________________________________________________________

Is this your first head injury □ Yes □ No. If no please list date of previous injury(s)_________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

List ALL major surgeries and/or hospitalization ___________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Patient Name ______________________________________ DOB ________________________ Today's Date____________ 

**FAMILY HISTORY** Have any of your (the patient's) relative- living or decease had any of these conditions?

| Ocular Disease/ Condition | Yes | No | Not Sure | Relationship to you |
|---|---|---|---|---|
| Blindness | ☐ | ☐ | ☐ | ____________________ |
| Eye Turn (Strabismus) | ☐ | ☐ | ☐ | ____________________ |
| Lazy Eye (Amblyopia) | ☐ | ☐ | ☐ | ____________________ |
| Glaucoma | ☐ | ☐ | ☐ | ____________________ |
| Retinal Detachment/Disease | ☐ | ☐ | ☐ | ____________________ |
| Other ______________________ | | | | ____________________ |

| Systemic Disease/ Condition | Yes | No | Not Sure | Relationship to you |
|---|---|---|---|---|
| Arthritis | ☐ | ☐ | ☐ | ____________________ |
| Cancer / Type ________________ | ☐ | ☐ | ☐ | ____________________ |
| Diabetes | ☐ | ☐ | ☐ | ____________________ |
| Heart Disease | ☐ | ☐ | ☐ | ____________________ |
| Kidney Disease | ☐ | ☐ | ☐ | ____________________ |
| Other ______________________ | | | | ____________________ |

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV/AIDS ☐ Syphilis ☐ Other________________ ☐ None

**PATIENT'S REVIEW OF SYSTEMS** Do you currently, or have you ever had any problems in the following areas:

| System | Yes | No | Not Sure | | System | Yes | No | Not Sure |
|---|---|---|---|---|---|---|---|---|
| **Skin (Integumentary)** | | | | | **Psychiatric** | | | |
| Psoriasis | | | | | ADHD/ ADD | | | |
| Other: | | | | | Dyslexia | | | |
| **Neurological** | | | | | Anxiety | | | |
| Headache / Migraine | | | | | Other: | | | |
| Seizures | | | | | **Ears, Nose, Mouth, Throat** | | | |
| Autism Spectrum / Asperger | | | | | Seasonal Allergies/ Hay fever | | | |
| Sensory Disorder | | | | | Sinus Congestion | | | |
| Cerebral Palsy | | | | | Runny Nose | | | |
| Vomiting | | | | | Chronic Cough | | | |
| Clumsiness | | | | | Dry Throat/ Mouth | | | |
| **Eyes** | | | | | **Respiratory** | | | |
| Loss of Vision | | | | | Asthma | | | |
| Blurred Vision | | | | | Chronic Bronchitis | | | |
| Distorted Vision / Halos | | | | | Emphysema | | | |
| Double Vision | | | | | **Vascular / Cardiovascular** | | | |
| Dryness / Sandy Gritty Feeling | | | | | Diabetes | | | |
| Mucus Discharge | | | | | Heart Pain | | | |
| Redness | | | | | High Blood Pressure | | | |
| Itching / Burning | | | | | Vascular Disease | | | |
| Excess Tearing / Watering | | | | | Brain Injury / Stroke | | | |
| Tired Eyes | | | | | Other: | | | |
| Eye Pain/ Soreness | | | | | **Gastrointestinal** | | | |
| Sties / Chalazion | | | | | Diarrhea and/or constipation | | | |
| Flashes / Floaters in Vision | | | | | **Bones/ Joint/ Muscles** | | | |
| **Endocrine** | | | | | Arthritis | | | |
| Thyroid / Other Glands | | | | | Muscle and/or Joint Pain | | | |
| Allergic/ Immunologic | | | | | Lymphatic/ Hematological | | | |
| Fever, Weight Loss/ Gain | | | | | Anemia/Bleeding Problems | | | |
| Other: | | | | | Other: | | | |

**PEDIATRIC VISION DEVELOPMENT CENTER**

NAME:________________________________________DOB: ___________________ DATE:___________________

VISUAL QUESTIONNAIRE

**Instructions:** Pose the following questions exactly as written. If the patient responds with "yes" - please qualify with frequency choices. Do not give examples.
**Patient instructions:** Please answer the following questions about how your eyes feel when reading or doing close work.

| | | Frequency | | | | |
|---|---|---|---|---|---|---|
| | Possible Subjective Symptoms | **Never (0)** | **Infrequently/ Not very often (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 while reading or doing close work? | | | | | |
| | **Total score** | | | | | |
| 15. | Do you notice one eye that turns In / Out / Up / Down (circle one) | | | | | |
| 16. | Blurry vision in the distance after prolonged close work? | | | | | |
| 17. | Closes one eye when reading or doing close work? | | | | | |
| 18. | Omits words when reading? | | | | | |
| 19. | Fills in the wrong bubbles on a computer graded test? | | | | | |
| 20. | Misaligns or misplaces numbers in columns? | | | | | |
| 21. | Poor handwriting, or writes uphill or down hill? | | | | | |
| 22. | Difficulty copying from the board at school? | | | | | |
| 23. | Writes letters and/or numbers backwards? | | | | | |
| 24. | Inconsistent performance in school? | | | | | |
| 25. | Inconsistent or poor at sports? | | | | | |
| 26. | Persistent difficulty learning to spell? | | | | | |
| | **Total score** | | | | | |

1. What are your/ parent's/ guardian's goals in neuro-vision rehabilitation?

____________________________________________________________

____________________________________________________________

____________________________________________________________

2. Are there any considerations in your participating in neuro-vision rehabilitation for us to be aware? ☐Yes ☐No
If yes, please explain (e.g., time availability, behavioral or physical limitations, etc) ____________________________________

____________________________________________________________

____________________________________________________________

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## MEDICAL RELEASE

I hereby understand and authorize Pediatric Vision Development Center obtain and/or exchange written and verbal information for the purpose of medical, visual, psychological, and/or educational evaluation. As vision therapy services at the Pediatric Vision Development Center can be a part of a multidisciplinary team, this authorization may include, but not limited to the following: Patient's eye care professional, referral professional, occupational therapist, physical therapist, speech therapist, behavioral therapist, school counselors/administrative, and pediatricians/medical physicians. The Pediatric Vision Development Center communicates with the patient/parent/guardian/ and the multidisciplinary team via: Fax, Email, Text, Postal mail, and/or Verbal communication. **Documents including but not limited to the following: initial evaluation reports, progress reports, letters of medical necessity, prescriptions, classroom accommodations may be emailed. ______ Initials**

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that my medical records include information regarding drug abuse/alcoholism/alcohol abuse/psychological/psychiatric conditions/ medical history including exposures or infections to diseases/ visual history and authorize the release of this information.

I do hereby release Pediatric Vision Development Center and its directors, agents, doctors, employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.

Patient/Parent/Guardian Signature______________________________________________ Date___________________________

Relationship to Patient_________________________________________ Print Name___________________________________

## HIPAA AGREEMENT

I acknowledge that I understand the Notice of Privacy Practices provided by the Pediatric Vision Development Center and a copy has been shown/ provided to me upon request.

Patient/Parent/Guardian Signature______________________________________________ Date___________________________

Relationship to Patient________________________________________ Print Name_____________________________________