**Lynn H. Trieu, OD, MS**
**Fellow, American Academy of Optometry**
**Fellow, College of Optometrists in Vision Development**

**True Vision Therapy, LLC**
**Pediatric Eye Care and Vision Therapy**
**Neuro-Optometry and Rehabilitation**

## Questionnaire for Pediatric Patients

**Today's Date _____Child's Name_____DOB _____**

**Age _____ Grade _____ F ☐ M ☐ ☐ Referred by _____**

**Address _____ City _____ State _____ Zip _____**

**Home Phone _____ Cell Phone _____ Email _____**

**Parents' Names – Parent 1: _____ Parent 2: _____**

**Occupations – Parent 1: _____ Parent 2: _____ Marital Status: Married ☐ Single ☐ Divorced ☐**

**Patient's Previous Diagnosis: _____**

Reason for your child's visit (including any visual symptoms your child is experiencing):

When did the problem(s) start?

### Visual History

Is this your child's first visual examination? Yes ☐ No ☐ If no, when was his/her last examination?

Who is your child's primary eye doctor? Name:

Address:

Phone:

Please describe any previous eye or vision problems and visual treatment your child has received (including glasses, vision therapy, patching, surgery, or medications).

**Please check any of the following that you or the teacher have noticed or that your child complains about:**

☐ blurred distance vision
☐ blurred vision during reading
☐ double vision
☐ fatigue during near visual tasks
☐ words moving or running together
☐ eye strain
☐ frequent headaches
☐ eyes cross or drift in/out or up/down
☐ closes one eye when reading
☐ holds reading material too close
☐ turns or tilts head
☐ squints or blinks excessively
☐ rubs eyes during reading
☐ skips or rereads words and lines
☐ loss of place when reading
☐ head movement when reading
☐ uses finger or underliner to read
☐ red or teary eyes
☐ avoids near work
☐ poor depth perception
☐ poor eye-hand coordination
☐ does not enjoy sports
☐ reverses numbers and letters
☐ transposes numbers and letters
☐ mistakes words w/ similar beginnings
☐ trouble learning right from left
☐ trouble learning basic math concepts
☐ poor recall of visual material
☐ responds better orally than in writing
☐ excessive erasing
☐ sloppy writing skills
☐ trouble copying from board to book
☐ other (please describe)

### Educational History

Do you feel your child is performing up to his/her potential in school? Yes ☐ No ☐

Has your child repeated any grades? Yes ☐ No ☐ If yes, which one?

Is your child receiving any tutoring, extra help, or special education classes in school? Yes ☐ No ☐ If yes, please describe.

Have there been any evaluations done at school or by school recommendation? (psychological, educational, speech/language, occupational therapy, neurological, hearing, or medical) Yes ☐ No ☐ If yes, please list name of professionals, tests performed, and briefly describe the results.

**Please check if your child has difficulty in any of the following areas:**

| | | |
|---|---|---|
| ☐ reading | ☐ handwriting | ☐ motivation |
| ☐ spelling | ☐ copying from the board | ☐ attention span |
| ☐ math | ☐ behavior | ☐ homework takes longer than it should |

**Please check if any of the following aspects of reading are difficult or are behaviors you have noticed:**

| | | |
|---|---|---|
| ☐ phonemic awareness | ☐ reading speed or fluency | ☐ omits/confuses small words |
| ☐ letter/word recognition | ☐ comprehension | ☐ fatigue/sleepiness |
| ☐ phonics/decoding | ☐ comprehension declines over time | ☐ avoidance of reading |

Does your child enjoy reading for pleasure? Yes ☐ No ☐

**Developmental History**

Were there any complications with pregnancy or during birth? Yes ☐ No ☐ If yes, please describe.

Was your child born prematurely? Yes ☐ No ☐ If yes, how early?

Was your child adopted? Yes ☐ No ☐

Does or did your child have any speech problems? Yes ☐ No ☐
Does or did your child have any problems with fine motor skills? Yes ☐ No ☐
Is your child clumsy or having any difficulty with activities requiring good balance? Yes ☐ No ☐
Does you child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc.? Yes ☐ No ☐

**Medical History**

Does your child suffer from any health problems, including any allergies or asthma? Yes ☐ No ☐ If yes, please describe.

Has your child had any severe childhood illnesses, injuries, or hospitalization? Yes ☐ No ☐ If yes, please describe.

Is your child taking any medications? Yes ☐ No ☐ If yes, please list:

When was your child's last physical examination?

Who is your child's pediatrician? Name:

Address:

Phone:

**Family History**

| Does anyone in the family have any of the following? | Relationship to Child |
|---|---|
| ☐ strabismus (crossed eyes or drifting eyes) | _____ |
| ☐ amblyopia (lazy eye) | _____ |
| ☐ high nearsightedness, farsightedness, or astigmatism | _____ |
| ☐ learning or reading problems | _____ |
| ☐ blindness | _____ |
| ☐ eye disease (please describe) | _____ |

Thank you for carefully completing this questionnaire.

**Lynn H. Trieu, OD, MS**
**Fellow, American Academy of Optometry**
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**office@truevisiontherapy.com**

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# Notice of Privacy Practices Acknowledgement

## Consent to use or disclose health information for the treatment, payment, and health care operations

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 that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers

True Vision Therapy has a comprehensive *Notice of Privacy Practices* that describes how the practice may use and disclose my health information. I may request a personal copy of the *Notice of Privacy Practices* at any time. By signing this document, I acknowledge that I have been offered a copy of the *Notice of Privacy Practices*. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please note that the *Notice of Privacy Practices* explains how True Vision Therapy contacts patients by phone, email, and text message about appointment times, recommended treatments, and in response to questions. I can consult the *Notice* for a full explanation of these practices. While True Vision Therapy's email and records are protected by HIPAA-compliant agreements, I acknowledge that my personal email, phone, and computer may not be. I also understand that if I prefer not to be contacted by any of the means outlined above, I may provide written notice to True Vision Therapy at any time.

I understand that I may request in writing that True Vision Therapy restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand True Vision Therapy is not required to agree to my requested restrictions, but if this practice does agree then it is bound to abide by such restrictions.

**I have reviewed, understand, and agree to the content of the notice of privacy practices and this consent. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.**

Patient name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please note your relationship as the source of authority to sign this form.

Signature: _____ Relationship: _____

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# Ocular Health Statement

## Reminder that our office does not perform ocular health examinations

I understand that **Dr. Lynn Trieu's evaluation is a functional eye examination**, meaning that it looks at how comfortably and easily the eyes work together in my everyday life. It is intended to examine eye alignment, the coordination of muscles around the eyes (extraocular muscles), and focusing (ciliary) muscles. Her examination neither confirms nor denies any ocular health condition outside of the functional vision examination.

**Dr. Trieu will not perform a routine ocular health check**. This means that she will not perform an examination of the external parts of my eye, including the eyelids, sclerae, cornea, and lens; she will not perform a dilated fundus exam to check the health of the retina and optic nerve; and she will not perform an intraocular pressure check. All of these procedures should be performed at a separate examination as part of my routine ocular health management.

If I do not have a primary eye care provider or know of one, this office is happy to recommend someone in my area. Dr. Trieu recommends regularly scheduled ocular health checks, especially for patients who are diabetic, hypertensive, have systemic diseases that may affect vision, have cataracts, have a strong glasses prescription, have had an eye injury, have a family history of eye disease, or are 45 years of age or older. An immediate ocular health check is recommended if I have any of the following symptoms:

1. Sudden appearance of a curtain or shadow coming over my field of vision.
2. Onset or marked increase of flashes of light, often similar to lightening streaks, which may be more noticeable in the dark.
3. Sudden change or decrease in vision in one eye or both eyes.
4. Sudden appearance of new cobwebs or spider-like figures in my vision.
5. Sudden appearance of many new black dots, commonly known as floaters.

**I have reviewed, understand, and agree to the above statement.**

Patient name: _____ Date: _____

Patient Signature: _____

If you are signing as a personal representative of the patient, please note your relationship as the source of authority to sign this form.

Signature: _____ Relationship: _____