Welcome to FOCUS Center for Vision and Learning, LLC

Sarah E. Lane, O.D.
NJ Lic# 6103

Child's name:_____ Sex:_____Today's Date:_____

Address:_____ Birthdate:_____Age:_____

City / State / Zip:_____ SSN:_____

Home phone:_____

Mother's name:_____ **Father's name**:_____

Email:_____ Email:_____

Occupation:_____Cell #:_____ Occupation:_____Cell #:_____

Employer:_____ Employer:_____

Preferred Method of Contact: ☐ Home Phone ☐Mother's Cell ☐ Father's Cell ☐Email

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Referred/Recommended by:_____ Contact Information:_____

When was your child's last eye exam?_____Doctor:_____Location:_____

Outcome of previous evaluation(s)?(glasses, contacts, therapy, etc.)_____

_____

Has your child ever worn glasses?_____ Distance Near Prism Bifocal (circle all that apply)

Has your child ever undergone eye surgery? ☐ No ☐ Yes _____

Reason for today's visit:_____

Is your child struggling in school? ☐ No ☐ Yes (please describe difficulty)_____

_____

School Name:_____Address:_____

Teacher's Name:_____Grade:_____IEP/ Special Services? ☐ Yes ☐No

Classroom Setting: ☐ Mainstream ☐Self-Contained

Details:_____

_____

Is your child pulled out of the classroom for extra support? ☐ Yes ☐ No

If Yes, for what subjects? What is the frequency?

Please provide information about prior vision training, vision rehabilitation or any other therapies including tutoring below:

Past Therapies	Dates of Therapy	Frequency	Therapist	Contact Information

Current Therapies	Dates of Therapy	Frequency	Therapist	Contact Information

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Do you notice any of the following?

Holding reading too close?	☐ Yes ☐ No	Distorted posture when reading?	☐ Yes ☐ No
Holding reading farther away?	☐ Yes ☐ No	Reading in bed?	☐ Yes ☐ No
Headaches?	☐ Yes ☐ No	Inability to see objects at distance?	☐ Yes ☐ No
Double Vision?	☐ Yes ☐ No	Inability to see objects at near?	☐ Yes ☐ No
Closing one eye?	☐ Yes ☐ No	Poor general coordination?	☐ Yes ☐ No
Covering one eye?	☐ Yes ☐ No	Bothered by light?	☐ Yes ☐ No
Frequent redness of eyes?	☐ Yes ☐ No	Enjoys swings?	☐ Yes ☐ No
Excessive eye rubbing?	☐ Yes ☐ No	Clumsy?	☐ Yes ☐ No
Loss of place when reading?	☐ Yes ☐ No	Likes sports?	☐ Yes ☐ No
Reading with finger?	☐ Yes ☐ No		

Please provide details of when and how often these are occurring: _____

_____

Developmental/ Childhood/ Health History

At what age did your child first:

crawl:_____ walk:_____ use first words:_____ speak in sentences:_____

Infections

Did your child experience infections in their first year of life? ☐ Yes ☐ No

If yes, how often did they occur?

_____

Did/ does your child experience frequent ear infections? ☐ Yes ☐ No

If yes, please specify:

_____

_____

Head Injury

Has your child ever experienced a head injury, whiplash injury or concussion? ☐ Yes ☐ No

If yes, please provide date, nature of the injury and visual problems that may be related:

_____

_____

_____

_____

_____

_____

Vaccinations

Has your child been vaccinated? ☐ Yes ☐ No

If yes, please list vaccinations:

_____

_____

Has the schedule been adjusted? ☐ Yes ☐ No

If yes, please specify:

_____

_____

Has your child experienced vaccination reactions? ☐ Yes ☐ No

If yes, please explain (fever, rash, swelling, seizure, loss of skills):

_____

_____

Medications

Is your child currently taking any medication? ☐ Yes ☐ No

Please list all medication your child uses (including over the counter medications, vitamins, supplements, and home remedies)?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Does your child have any allergies/ sensitivities? (**medication**, food, chemical, seasonal, etc.) ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Illness

Did/ does your child suffer from any illness? ☐ Yes ☐ No

If yes, please specify:

_____

_____

_____

_____

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Previous Diagnoses

- ☐ Afebrile Seizures
- ☐ Allergies
  If yes, please explain_____
  _____
- ☐ Anemia
- ☐ Anxiety
- ☐ Asperger's Syndrome
- ☐ Attention Deficit Disorder
- ☐ Auditory Processing Deficiency
- ☐ Autism
- ☐ Cancer
  If yes, please explain_____
  _____
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Conduct Disorder
- ☐ Childhood Disintegrative Disorder (CDD)
- ☐ Down Syndrome
- ☐ Diabetes
- ☐ Developmental Language Disorder
- ☐ Dyslexia
- ☐ Dysgraphia (handwriting)
- ☐ Eczema
- ☐ Epilepsy
- ☐ Febrile seizures
- ☐ Fetal Alcohol Syndrome
- ☐ Frequent Ear Infections
- ☐ Gastroesophageal Reflux (Acid Reflex)
- ☐ Hearing Loss
- ☐ Irritable Bowl Syndrome
- ☐ Learning Disabilities
  If yes, please explain_____
  _____
- ☐ Mental Retardation
- ☐ Migraines
- ☐ Mononucleosis/ Epstein Barr Visus
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus (PANDAS)
- ☐ Pervasive Developmental Disorder (PDD-NOS)
- ☐ Pediatric Emotional Disorder
- ☐ Rett's Syndrome
- ☐ Scoliosis
- ☐ Speech Delay
- ☐ Tourette's Syndrome
- ☐ Other Chromosomal/ Genetic Abnormality

_____

_____

_____

_____

_____

Family History

Please note any family history (parents, grandparents, siblings, children; (living or deceased)) for the following conditions:

Disease/ condition	No	Yes	?	Relationship to you
Asthma	□	□	□	
Blindness	□	□	□	
Cataract	□	□	□	
Crossed Eyes	□	□	□	
Glaucoma	□	□	□	
Macular degeneration	□	□	□	
Retinal detachment/ Disease	□	□	□	
Arthritis	□	□	□	
Cancer (specify type)	□	□	□	
Diabetes	□	□	□	
Heart Disease	□	□	□	
High Blood Pressure	□	□	□	
Kidney Disease	□	□	□	
Lupus	□	□	□	
Thyroid Disease	□	□	□	

Review of Systems

Do you currently, or have you ever had any of the problems in the following areas:

System	No	Yes	?
CONSTITUTIONAL			
Fever, weight loss/gain	□	□	□
INTEGUMENTARY (SKIN)			
Psoriasis	□	□	□
Acne Rosacea	□	□	□
NEUROLOGICAL			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
EYES			
Loss of vision	□	□	□
Blurred vision	□	□	□
Distorted vision	□	□	□
Loss of side vision	□	□	□
Double Vision	□	□	□
Tired eyes	□	□	□
Eye Strain	□	□	□
Dryness	□	□	□
Mucous discharge	□	□	□
Redness	□	□	□
Sandy or gritty feeling	□	□	□
Itching	□	□	□
Burning	□	□	□
Foreign body sensation	□	□	□
Excessive tearing/ watering	□	□	□
Glare/ light sensitivity	□	□	□
Eye pain or soreness	□	□	□
Chronic infection of Eye/ Lid	□	□	□
Sty or Chalazion	□	□	□
Flashes or floaters	□	□	□
ENDOCRINE			
Thyroid Gland	□	□	□
Pituitary Gland	□	□	□
Diabetes	□	□	□

	No	Yes	?
EAR, NOSE, MOUTH, THROAT			
Allergies/ hay fever	□	□	□
Sinus congestion	□	□	□
Runny nose	□	□	□
Post nasal drip	□	□	□
Chronic cough	□	□	□
Dry mouth/ throat	□	□	□
RESPIRATORY			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
VASCULAR / CARDIOVASCULAR			
Heart pain	□	□	□
High Blood pressure	□	□	□
Vascular disease	□	□	□
Heart attack or stroke	□	□	□
GENITOURINARY			
Genitals/ Kidney/ Bladder	□	□	□
Reproductive system	□	□	□
Prostate (men)	□	□	□
GASTROINTESTINAL			
Chronic diarrhea or constipation	□	□	□
BONE / JOINTS			
Rheumatoid Arthritis	□	□	□
Muscle pain	□	□	□
Joint pain	□	□	□
LYMPHATIC / HEMATOLOGIC			
Anemia	□	□	□
Bleeding problems	□	□	□
Hepatitis	□	□	□
HIV	□	□	□
Cancer	□	□	□
ALLERGIC / IMMUNOLOGIC	□	□	□
PSYCHIATRIC			
Depression	□	□	□
Anxiety	□	□	□

If you answered yes to any of the above, please explain:_____

_____

Patient signature:_____ **Doctor's signature:**_____ **Date:**___

Changes:_____ **Date:**_____ **Px:**_____ **Doc:**___

Changes:_____ **Date:**_____ **Px:**_____ **Doc:**___

Changes:_____ **Date:**_____ **Px:**_____ **Doc:**___

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Convergence Insufficiency Symptom Survey (CISS)

Please ask these questions of your child and fill in the appropriate boxes with an ✕ indicting the frequency of each symptom.

Possible Subjective Symptom	Never	Infrequently/ Not often	Sometimes	Fairly Often	Always
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: (to be completed by the doctor)_____

Notes:_____

_____

Reference:Borsting EJ, Rouse MW, Mitchell GL, et al and the SITT group. Validity and reliability of the revised convergence insufficiency symptom survey in children. Optometry and Vision Science 2003; 80(12):832-838

Brain Injury Questionnaire

Child Name:_____DOB:_____Age:_____
Date of injury:_____
Nature of injury: _____

Please provide information about immediate rehabilitation time: (therapies, surgeries, progress):_____

Was medication used during the initial rehabilitation time? If so please provide name of medication and duration of use.

What medications are you currently using? Please provide, name, dose and condition/ symptoms being treated.

What activities were you doing before the injury that you would like to be doing again?_____

Please circle areas of difficulty or concern:

Reading	Driving	Light sensitivity	Body coordination
Writing	Walking/ running	Dizziness	Memory
Computer work Balance	Feeling overwhelmed	Headaches	Sensitivity to sounds
Self care	Sports/ exercise	Diet/ nutrition	

Other:_____

Please provide any details pertaining to the above concerns:_____

Please provide details of current therapies. Please include therapist name, modality, frequency of treatment, goals and indicators of progress._____

Birth History Questionnaire

Child Name:_____DOB:_____Age:_____

This questionnaire is designed to provide a profile of your child's birth experience. The information provided here will serve an important purpose in putting together the pieces of your child's developmental history and current symptoms. The information provided may help Dr. Lane develop correlations to the visual difficulties detected. Sharing this information with Dr. Lane helps her formulate a complete picture of your child's early experiences and development. Your willingness to share this information is appreciated.

Was your child Adopted? Yes or No
If yes, please provide as much information as possible.
Mother's Age at time of birth:_____
Gestational age at birth:_____
Birthplace (home, hospital, planned, unplanned):_____
_____
_____
City, State:_____
Birth weight:_____
Birth order (1st born, 2nd, 3rd...):_____

Did you attend a childbirth preparation class?
Yes or No, If yes, which method?_____
_____
What type of care provider did you use? (circle one)
OB/GYN, Midwife, Family Practitioner
Did you work with a doula? Yes or No
Was this child born by VBAC? (Vaginal Birth After Cesarean) yes or no, If yes, how many cesareans occurred before this birth? _____

Use the sections below to provide information about you and your child's experience during pregnancy, birth and after birth.

Pregnancy:
Check all that apply to your perception of your child's birth

Calm	□	Dramatic	□	Sad	□
Safe	□	Painful	□	Angry	□
Supported	□	Empowering	□	Happy	□
Trusted	□	Energizing	□	Satisfying	□
Stressful	□	Exhausting	□	In control	□
Hard	□	Out of control	□	Healthy	□
Long	□	Prepared	□	Scared	□
Emergency	□	Upsetting	□	Elated	□

Please provide the following information about your pregnancy:

Did you have difficulty conceiving this child? **Yes or No,** If yes, what treatments or practices did you use to boost your fertility?_____
_____
Was your child conceived through IVF? **Yes or No** If yes, how many embryos were implanted?_____

Is your child the result of a multiple pregnancy? **Yes or No** If yes, provide the health outcome for each child._____
_____
_____

Pregnancy Information Continued…

Was bed rest recommended during your pregnancy? **Yes or No** If yes, why, when and for how long, _____

_____

_____

Did you experience significant illness during pregnancy? **Yes or No** If yes, provide details, _____

_____

Did you use antibiotics during pregnancy? **Yes or No** If yes, which one, why and how long was the course?_____

_____

Did you receive vaccination during pregnancy? **Yes or No**, If yes, provide which one(s) were given and at which week of gestation?

Did any complications result from vaccination? _____

_____

_____

Did you receive ultrasound monitoring during your pregnancy? **Yes or No**
How many ultrasounds were completed? _____At what weeks?_____

Was ultrasound used to monitor a specific concern or condition? **Yes or No** If yes, provide information:_____

_____

_____

Did you receive any extended ultrasounds? **Yes or No**, If yes, how many and what was the duration of the sessions._____

_____

_____

Did you receive an entertainment ultrasound? **Yes or No**
If yes, how long were you watching the baby?_____

Were you ever told that your baby was "big"? **Yes or No** If yes, how did it change your birth plan?_____

_____

Did you test positive for Group B Strep? **Yes or N**o If yes, what treatment did you receive?_____

_____

Were you diagnosed with gestational diabetes? **Yes or No** If yes, what treatment and recommendations did you follow?_____

_____

_____

Were you diagnosed with high blood pressure? **Yes or No** If yes, did you receive treatment?_____

_____

Did you experience preterm labor (labor before 37 weeks)? **Yes or No** If yes, what treatment did you receive (steroids, magnesium other)_____

_____

Did you experience depression or anxiety during your pregnancy? **Yes or No**, If yes, provide details:_____

_____

_____

Please provide the following information about your labor and birth:

Was your labor induced? **Yes or No**, If yes, in what way? (Prostaglandin/ Cervadil/Cytotec/Pitocin)_____

_____

When did your water break/ membranes release? _____Wks. How soon after did your labor begin?_____

Was a procedure completed to assist in your water breaking/ membranes releasing? **Yes or No**, If yes, provide details_____

_____

Did you receive epidural anesthesia? **Yes or No** If yes, do you recall the specific medication used?

_____

Did you receive antibiotics around the time of labor? **Yes or No** If yes, why? (Group B Strep, delayed labor)

_____

How was your labor monitored? **External Fetal Monitor / Internal Fetal Monitor / fetoscope / doppler**

Were you able to move and change position during labor? **Yes or No** Provide information on the positions that you utilized during labor. _____

_____

_____

Were forceps used during birth? **Yes or No**

Was vacuum extraction used? **Yes or No**

If yes to either, were there effects from the procedure?

_____

Did you receive an episiotomy? **Yes or No**, If yes, did you experience any lasting complications or require additional procedures?

_____

_____

How long did you "push" during labor? _____

Was your child born by cesarean section? **Yes or No**
If yes, was it planned/ scheduled or emergency? _____

_____

Provide details of the decision to perform a cesarean section? (Maternal health, fetal distress, prolonged labor, failure to progress

_____

_____

Please provide the following information about your postpartum experience:

Did your child receive oxygen after birth?

Were you separated after birth? Was your child admitted to the NICU? If yes, for how long?

Did your baby immediately nurse after birth? **Yes or No**

Was your child breastfed? **Yes or No** Please provide comments about feeding behavior and duration of nursing.

Did your child receive vaccination(s) in the first day after birth? **Yes or No Which one(s)?** _____

Did your child experience any reactions to the vaccination(s)? **Yes or No If yes, provide details**. _____

Did your child have a tongue/lip tie? **Yes or No If yes, was the tie medically released (clipped of lasered) and at what age?**

The information provided may be included in research publication and presentations in the future. Please sign indicating your consent for the use of this information. No names or identifying details will be included in publication or presentation. Close attention will be paid to maintain patient confidentiality and privacy.

Printed Name: _____ Signature: _____ Date: _____

Dr. Sarah Lade, OD
Focus Center for Vision and Learning
HIPAA Release Form

This form gives Dr. Lane permission to discuss the patient's evaluation findings, therapy notes and progress, and diagnosis with other teachers, therapists and healthcare providers. A printed report of Dr. Lane's findings will be provided to the patient/guardian. The patient or guardian is responsible for providing copies of the report to 3rd parties.

Patient Name: _____ Date of Birth: _____/____/_____

Parent/Guardian Name:_____

Release of Information

[ ] I authorize the release of information including the examination findings, diagnosis, records, and therapy notes/progress regarding _____ at Focus Center for Vision and Learning.
This information may be released to:
[ ] Teachers: _____
[ ] Therapists:_____
[ ] Doctors: _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature:_____ Date:_____