Nancy M. Mackowsky, OD, PA

The Mackowsky
Visual Learning &
Rehabilitation Clinic

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Child Medical Questionnaire

IMPORTANT: Please fill out this questionnaire in black ink and bring with you to your appointment. The information on this form will enable Dr. Mackowsky to ascertain and evaluate your needs most effectively. Please also forward any other pertinent records to our office prior to this initial visit. Thank you and we look forward to meeting you.

I. Child's Information

Today's Date: _____

Patient's Full Name:_____ DOB:____/____/_____ AGE:_____ ☐ Male ☐ Female

Parent's Names:_____Home Phone: _____Work/Cell Phone: _____

Address:_____City:_____State:_____Zip Code:_____

E-Mail:_____School: _____Grade:_____

Medical Dr: _____Phone #:_____Medical Insurance Co.: _____

Name of Policy Holder: _____ID #:_____Grp #:_____

Co-pay for **In-Network** Office:regular $_____/specialist $_____Policyholder's Place of Employment: _____

Policyholder's Job Titile: _____Policyholder's Birthdate: ____/_____/_____**Yearly deductible met? Y/N**

HSA insurance acct? _____ High Deductible ($1000 or more)? Referred by_____

II. Major Concerns/Chief Complaint

Please describe the reason for this evaluation. (Please include onset, what are the signs/symptoms, severity and any modifying factors).

_____

III. Visual History

Has there been previous visual care? **YES** ☐ **NO** ☐ If yes, date of last exam:_____

Name of Eye Doctor:_____ (Please have these records faxed to our office)

Results and recommendations:_____

Please circle if glasses, contact lenses, or other optical device was prescribed/recommended. Does your child use them? **YES** ☐ **NO** ☐

How long has your child had them:_____ If used, when?_____if not used, why not?_____

If contact lenses are worn, how long has your child worn them?_____Please circle what type of lenses worn: gas permeable or soft

Does your child report or have you noted any of the following? Please check (☐) all areas of concern.

1. Blurred vision (far) ☐
2. Blurred vision (near) ☐
3. Headaches ☐
4. Avoids close work ☐
5. Squints to see blackboard ☐
6. Fatigues easily during visual tasks ☐
7. Frequent eye rubbing or blinking ☐
8. Loses place often when reading ☐
9. Repeatedly omits "small" words ☐
10. Skips or rereads words/lines ☐
11. Uses finger/marker to keep place ☐
12. Poor reading comprehension ☐
13. Complains of seeing double ☐
14. One eye turns (in, out, up or down) ☐
15. Covers or closes one eye ☐
16. Tilts/turns head to one side ☐
17. Moves head when reading ☐
18. Mistakes words with similar beginnings or endings ☐
19. Complains of letters/lines "floating", "running together" or "jumping" ☐

IV. Academic Problems

Specifically describe any school difficulties:_____

_____

Has a grade been repeated? **YES** ☐ **NO** ☐ Which grade(s)?_____

Has your child ever failed end-of grade reading test? **YES** ☐ **NO** ☐

Is child on grade level with reading? **YES** ☐ **NO** ☐ If no, what is approximate reading grade level:_____

Does your child like to read? **YES** ☐ **NO** ☐ Voluntarily? **YES** ☐ **NO** ☐ Does your child read for pleasure? **YES** ☐ **NO** ☐

Overall schoolwork is: above average ☐ average ☐ below average ☐

Which subjects are average/above average?_____

Which subjects are below average?_____

Does your child need to spend a lot of time/effort to maintain this level of performance? **YES** ☐ **NO** ☐

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

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** ☐

Does your child report or have you noted any of the following? Please check (☐) all areas of concern.

21. Confuses left/right directions ☐
22. Confuses b-d-p-q ☐
23. Reverses letters/words when writing/copying ☐
24. Difficulty sounding out unfamiliar words ☐
25. Fails to recognize same word in next sentence ☐
26. Confuses likenesses and minor differences ☐
27. Mistake words with similar beginnings ☐
28. Difficulty recognizing letters or simple forms ☐
29. Inability to line up math problems ☐
30. Difficulty copying from black board ☐
31. Difficulty distinguishing main idea from insignificant details ☐
32. Does your child have an awkward gait? ☐
33. Demonstrates poor memory ☐
34. Trouble writing/remembering letters/numbers ☐
35. Cannot remember exact order of items in left to right sequence ☐
36. Difficulty retaining spelling words from week to week ☐
37. Confuses similar beginnings and endings of words ☐
38. Unable to "picture" descriptions or instructions ☐
39. Demonstrates poor reasoning and learning strategies ☐
40. Difficulty relating letters to their relevant sounds ☐
41. Poor reading speed ☐
42. Sloppy drawing or writing skills ☐
43. Difficulty manipulating or handling small objects ☐
44. Cannot complete written tasks in allotted time ☐
45. Difficulty catching/hitting ball/dislikes sports ☐
46. Short attention span ☐
47. Distractible ☐

Which hand does your child prefer to write with? ☐ right ☐ left Always? ☐ yes ☐ no

V. Birth History

	YES	NO	
Was birth on time?	☐	☐	premature ☐ late ☐ Birth weight:_____lbs _____oz
Complications during pregnancy?	☐	☐	Describe:_____
Did smoking occur during pregnancy?	☐	☐	
Did alcohol consumption occur during pregnancy?	☐	☐	
Were forceps used?	☐	☐	Apgar score at birth:_____ After 10 minutes:_____

VI. Developmental History

Did your child reach the following developmental milestones at the appropriate age?

	Norm	Early	Average	Slow	Comments:
Sit alone	8 mo.	☐	☐	☐	
Crawl alone	9 mo.	☐	☐	☐	
Stand alone	15 mo.	☐	☐	☐	
Walk alone	15 mo.	☐	☐	☐	
Develop proper balance	4 yrs.	☐	☐	☐	
Dressing oneself	4 yrs.	☐	☐	☐	
Lacing shoes	5 yrs.	☐	☐	☐	
Develop left/right awareness	6 yrs.	☐	☐	☐	

VII. Medical History

Illnesses:	YES	NO	Age		YES	NO	Age		YES	NO	Age
Head Trauma/Injury	☐	☐	____	Ear/Nose/Mouth/Throat	☐	☐	____	Hematological/Lymphatic	☐	☐	____
Seizures/Neurological	☐	☐	____	Gastrointestinal	☐	☐	____	Allergic/Immunololgic	☐	☐	____
ADD/ADHD	☐	☐	____	Genitourinary	☐	☐	____	Other:_____			
Asthma/Respiratory	☐	☐	____	Musculoskeletal	☐	☐	____	_____			
Cardiovascular	☐	☐	____	Integumentary (skin)	☐	☐	____	_____			
Diabetes/Endocrine	☐	☐	____	Psychiatric	☐	☐	____	_____			

Are there any medications your child takes frequently? Please include name and purpose._____

_____

VIII. Speech-Auditory History

	YES	NO		YES	NO
Does your child turn his/her head to one side to listen?	☐	☐	Delayed speech?	☐	☐
Is there any history of ear infections?	☐	☐	Is speech clear?	☐	☐
Has there been any auditory testing?	☐	☐			

If yes, when:_____

IX. Family Medical History

Is there any family history of any medical conditions or eye disease (please list): _____

_____

_____

_____

X. Previous Evaluations (ie. Speech and hearing, psychological, neurological)

By whom_____Date_____

Address_____

Reason_____

Results and Recommendations:_____

XI. Special Services/Therapy (ie. occupational, physical, speech)

By whom_____Date_____

Address_____

Reason?_____

Type of Treatment_____

Dates of Treatment_____

XII. Goals

Please list what the goals are for coming to our office: _____

_____

_____

Do you have a computer: YES ☐ NO ☐ Do you have internet access: YES ☐ NO ☐

Does your child use a wheelchair? YES ☐ NO ☐ Can your child sit in an examination chair? YES ☐ NO ☐

XIII. Accommodations Request for School (please check any below if you would like accommodations included with your report)

Please check any of the below accommodations you feel would be beneficial for your child:

☐ Allow extra time for completion of assignments ☐ Allow frequent short breaks ☐ Allow verbal responses

☐ Allow use of ruler or finger as a guide to help track ☐ Provide peer note-taker ☐ Provide visual aids

☐ Provide written outlines ☐ Seat student near the board ☐ Minimize computer use

☐ Write key points on the board ☐ Read test items to students ☐ Test in a Separate Room

☐ Mark in Test Book/no bubbling answers on sheets ☐ Multiple Testing Sessions ☐ Increase font size for test taking

☐ Test Administrator Reads Test Aloud **Other** _____

XIV. Other

Please use the following scale to rate each: None Mild Moderate Severe

0 1 2 3 4 5 6

____ Headache	____ Dizziness	____ Sleeping more than usual	____ Attention difficulty	____ Motion sensitivity
____ Nausea	____ Lightheadedness	____ Sleeping less than usual	____ Feeling slowed down	____Ruminating thoughts
____ Vomiting	____ Balance problems	____ Drowsiness	____Sadness/hopelessness	_____ Difficulty in Math
____ Sensitivity to light	____ Numbness/tingling	___ Difficulty concentrating	____ Nervous/anxious	_____ Difficulty reading
____ Sensitivity to noise	____ Fatigue	____ Feeling mentally foggy	____ Irritability	____ Symptoms worse
____ Visual Problems	____ Trouble falling asleep	____ Difficulty remembering	____ More emotional	at end of day

XV. Insurance Filing and Release of Information

Dr. Mackowsky uses photos and videos during her examination to evaluate posture/balance/visual spatial awareness. Your signature below gives her permission to photograph and video tape (to be used exclusively in the office) to determine the best treatment modality for the below patient.

We will file all in-network insurance claims and will provide invoices for you to file out-of-network claims. Your signature below signifies you realize you will be responsible for all copays/deductibles/non-covered services on the date the service is rendered, if you are in- network.

It is also often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Your signature below permits information from, or copies of, your examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Dr. Mackowsky when it is necessary for the treatment of your visual condition, or for the

processing of insurance claims. I authorize Dr. Mackowsky to exchange information with other professionals involved in my or my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Patient or Representative Signature _____Date _____

Relationship to Patient (if applicable):_____

Please be on time for your appointment to allow Dr. Mackowsky the full hour for her evaluation. Late arrivals will be rescheduled. We also request a minimum of 48 hours notification to reschedule an existing appointment. Thank you.

Dr. Mackowsky's Signature _____Date _____