

## The Mackowsky Visual Learning & Rehabilitation Clinic

Blue Ridge Plaza 4505 Fair Meadow Lane, Suite 207, Raleigh, NC 27607  
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### Infant/Toddler 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. Infant'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 Title: \_\_\_\_\_ 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 (ie, what type of problem is noted, who first noted the vision problem, when, frequency, etc.)

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Did the problem occur suddenly (please detail)?

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Do your child's problems seem to be related to illness, accident, or other trauma?

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Have you noticed any differences in this child as compared to siblings or other children?

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Does your child like to be read to? ☐ Yes ☐ No

**Motor Control:**

Which hand does your child prefer to use for eating? ☐ Left ☐ Right Always? ☐ Yes ☐ No ☐ Not applicable

Does your child have an awkward gait? ☐ Yes ☐ No ☐ Not applicable

Is your child exceptionally clumsy? ☐ Yes ☐ No ☐ Not applicable

**III. Pregnancy and Delivery History****During Pregnancy**

	Yes	No		Yes	No
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Adequate and regular nutrition during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Use of internal medications during pregnancy If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>	Toxemia (blood poisoning)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive smoking?	<input type="checkbox"/>	<input type="checkbox"/>	Major illness or trauma	<input type="checkbox"/>	<input type="checkbox"/>
Excessive alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Other abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Labor- spontaneous with no complications?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____		

**Labor and Delivery**

Length of Pregnancy \_\_\_\_\_ Birth Weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Length \_\_\_\_\_ in.

	Yes	No		Yes	No
Blood exchange transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Severe jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anoxia (lack of oxygen)	<input type="checkbox"/>	<input type="checkbox"/>	Resuscitation	<input type="checkbox"/>	<input type="checkbox"/>
Incubator	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Poor sucking	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal cry	<input type="checkbox"/>	<input type="checkbox"/>
Cord around neck	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify? _____		

**IV. Infant/Toddler's Medical History****Illnesses:**

	Yes	No	Age		Yes	No	Age
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Serious infection or injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Reactions to drugs, vaccine allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies- specify? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hospitalization- specify? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent respiratory infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles (severe)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other? _____			
High fever	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Is your child receiving any medication at this time? ☐ Yes ☐ No If yes, list name and purpose?

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## V. Developmental History

### Gross Motor History:

Were there any problems with the following:

		Yes	No	Explain
Neck control development	4 mo.	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting alone	8 mo.	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling alone	9 mo.	<input type="checkbox"/>	<input type="checkbox"/>	
Stand alone	15 mo.	<input type="checkbox"/>	<input type="checkbox"/>	
Walk alone	15 mo.	<input type="checkbox"/>	<input type="checkbox"/>	

### Speech-Auditory History:

		Norm	Early	Average	Slow	
Da-da, etc.	9 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 words	12 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 words	15 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Short sentences	24 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gives full name	30 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child reply appropriately to simple directions and questions? ☐ Yes ☐ No

Does your child have to look at you to understand what you say? ☐ Yes ☐ No

### Vision History:

Have you noticed your child:

	Yes	Sometimes	No	When and how often do these symptoms occur?
Avoiding bright lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rubbing eye frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developing sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blinking excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Having red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting too close to the TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## VI. Previous Evaluations

Vision- for what reason? \_\_\_\_\_

By whom \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Neurological- for what reason? \_\_\_\_\_

By whom \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Other- for what reason? \_\_\_\_\_

By whom \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Please request copies of all previous evaluations/reports be sent to us prior to exam date to complete our history of your child.

## VII. Family Medical History

Family history to three generations. If yes, please specify relationship.

	Yes	No	Relationship
Multiple births	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hereditary diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuropsychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading and writing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	Relationship
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auditory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epileptic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthmatic	<input type="checkbox"/>	<input type="checkbox"/>	_____

## VIII. Goals

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

## IX. Parent or Guardian Information (if different from front page)

Father's/Mother's (or Guardian) name \_\_\_\_\_

Street address (if different from child's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

E-mail \_\_\_\_\_ Occupation or position \_\_\_\_\_

Do you have a computer: YES ☐ NO ☐

Do you have internet access: YES ☐ NO ☐

## XIII. 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 Parent 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 \_\_\_\_\_