

**The Mackowsky
Visual Learning &
Rehabilitation Clinic**

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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.)

Did the problem occur suddenly (please detail)?

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

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

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 applicableDoes your child have an awkward gait? Yes No Not applicableIs 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	<input type="checkbox"/>	<input type="checkbox"/>	Toxemia (blood poisoning)	<input type="checkbox"/> <input type="checkbox"/>
If yes, what?				
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-	<input type="checkbox"/> <input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	specify?		
Measles (severe)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent respiratory infections	<input type="checkbox"/> <input type="checkbox"/>	_____
High fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other?		

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

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 checked="" type="checkbox"/>	_____
Sitting alone	8 mo.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Crawling alone	9 mo.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Stand alone	15 mo.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Walk alone	15 mo.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____

Speech-Auditory History:

Norm **Early** **Average** **Slow**

Da-da, etc.	9 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
2 words	12 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
4 words	15 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Short sentences	24 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Gives full name	30 mo.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	_____
Rubbing eye frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Developing sties	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Blinking excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Having red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Sitting too close to the TV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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		Yes	No	Relationship
Multiple births	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hereditary diseases	<input type="checkbox"/>	<input type="checkbox"/>	Auditory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Neuropsychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic	<input type="checkbox"/>	<input type="checkbox"/>
Reading and writing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Asthmatic	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<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 _____