

## The Mackowsky Visual Learning & Rehabilitation Clinic

Blue Ridge Plaza 4505 Fair Meadow Lane, Suite 207, Raleigh, NC 27607  
Telephone: (919) 787-7600 Fax: (919) 787-7603 [Victoria.Martino@DrMackowsky.com](mailto:Victoria.Martino@DrMackowsky.com)

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

- |                                                                    |                          |                                                           |                          |
|--------------------------------------------------------------------|--------------------------|-----------------------------------------------------------|--------------------------|
| 1. Confuses left/right directions                                  | <input type="checkbox"/> | 15. Cannot remember exact order of items in left          |                          |
| 2. Confuses b-d-p-q                                                | <input type="checkbox"/> | to right sequence                                         | <input type="checkbox"/> |
| 3. Reverses letters/words when writing/copying                     | <input type="checkbox"/> | 16. Difficulty retaining spelling words from week to week | <input type="checkbox"/> |
| 4. Difficulty sounding out unfamiliar words                        | <input type="checkbox"/> | 17. Confuses similar beginnings and endings of words      | <input type="checkbox"/> |
| 5. Fails to recognize same word in next sentence                   | <input type="checkbox"/> | 18. Unable to "picture" descriptions or instructions      | <input type="checkbox"/> |
| 6. Confuses likenesses and minor differences                       | <input type="checkbox"/> | 19. Demonstrates poor reasoning and learning strategies   | <input type="checkbox"/> |
| 7. Mistake words with similar beginnings                           | <input type="checkbox"/> | 20. Difficulty relating letters to their relevant sounds  | <input type="checkbox"/> |
| 8. Difficulty recognizing letters or simple forms                  | <input type="checkbox"/> | 21. Poor reading speed                                    | <input type="checkbox"/> |
| 9. Inability to line up math problems                              | <input type="checkbox"/> | 22. Sloppy drawing or writing skills                      | <input type="checkbox"/> |
| 10. Difficulty copying from black board                            | <input type="checkbox"/> | 23. Difficulty manipulating or handling small objects     | <input type="checkbox"/> |
| 11. Difficulty distinguishing main idea from insignificant details | <input type="checkbox"/> | 24. Cannot complete written tasks in allotted time        | <input type="checkbox"/> |
| 12. Awkward gait                                                   | <input type="checkbox"/> | 25. Difficulty catching/hitting ball/dislikes sports      | <input type="checkbox"/> |
| 13. Demonstrates poor memory                                       | <input type="checkbox"/> | 26. Short attention span                                  | <input type="checkbox"/> |
| 14. Trouble writing/remembering letters/numbers                    | <input type="checkbox"/> | 27. Distractible                                          | <input type="checkbox"/> |

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

#### V. Birth History

|                                                 | YES                      | NO                       |                                                                                                   |
|-------------------------------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------|
| Was birth on time?                              | <input type="checkbox"/> | <input type="checkbox"/> | premature <input type="checkbox"/> late <input type="checkbox"/> Birth weight: _____ lbs _____ oz |
| Complications during pregnancy?                 | <input type="checkbox"/> | <input type="checkbox"/> | Describe: _____                                                                                   |
| Did smoking occur during pregnancy?             | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                   |
| Did alcohol consumption occur during pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                   |
| Were forceps used?                              | <input type="checkbox"/> | <input type="checkbox"/> | 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.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Crawl alone                  | 9 mo.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Stand alone                  | 15 mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Walk alone                   | 15 mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Develop proper balance       | 4 yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Dressing oneself             | 4 yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Lacing shoes                 | 5 yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Develop left/right awareness | 6 yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |

## VII. Medical History

| Illnesses:            | YES                      | NO                       | Age   |                       | YES                      | NO                       | Age   |                         | YES                      | NO                       | Age   |
|-----------------------|--------------------------|--------------------------|-------|-----------------------|--------------------------|--------------------------|-------|-------------------------|--------------------------|--------------------------|-------|
| Head Trauma/Injury    | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Ear/Nose/Mouth/Throat | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hematological/Lymphatic | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures/Neurological | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gastrointestinal      | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Allergic/Immunologic    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ADD/ADHD              | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Genitourinary         | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other:                  |                          |                          | _____ |
| Asthma/Respiratory    | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Musculoskeletal       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |                         |                          |                          | _____ |
| Cardiovascular        | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Integumentary (skin)  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |                         |                          |                          | _____ |
| Diabetes/Endocrine    | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Psychiatric           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |                         |                          |                          | _____ |

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? | <input type="checkbox"/> | <input type="checkbox"/> | Delayed speech?     | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any history of ear infections?                  | <input type="checkbox"/> | <input type="checkbox"/> | Is speech clear?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Has there been any auditory testing?                     | <input type="checkbox"/> | <input type="checkbox"/> | Wears hearing aids? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, when/where: _____                                |                          |                          |                     |                          |                          |

## 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- please fax copy of most recent report)

By whom \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Reason \_\_\_\_\_  
Results and Recommendations: \_\_\_\_\_

## XI. Special Services/Therapy (ie. occupational, physical, speech- please fax copy of last therapy evaluation)

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:

- |                                                                                |                                                       |                                                       |
|--------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Allow extra time for completion of assignments        | <input type="checkbox"/> Multiple Testing Sessions    | <input type="checkbox"/> Allow verbal responses       |
| <input type="checkbox"/> Allow use of ruler or finger as a guide to help track | <input type="checkbox"/> Test in a Separate Room      | <input type="checkbox"/> Allow slant board use        |
| <input type="checkbox"/> Provide written outlines                              | <input type="checkbox"/> Increase font size for tests | <input type="checkbox"/> Minimize computer use        |
| <input type="checkbox"/> Write key points on the board                         | <input type="checkbox"/> Allow frequent short breaks  | <input type="checkbox"/> Provide peer note-taker      |
| <input type="checkbox"/> Mark in Test Book/no bubbling answers on sheets       | <input type="checkbox"/> Seat student near the board  | <input type="checkbox"/> Assistive Technology devices |
| <input type="checkbox"/> Test Administrator Reads Test Aloud                   | <u>Other</u> _____                                    |                                                       |

## XIV. Other

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

0      1      2      3      4

|                          |                            |                              |                          |                         |
|--------------------------|----------------------------|------------------------------|--------------------------|-------------------------|
| ___ 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 \_\_\_\_\_