# 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 (MM / DD / YYYY) | Patient's Full Name | | | DOB (MM / DD / YYYY) |
| AGE | Male / Female<br>☐ Male ☐ Female | Parent's Names | | |
| Home Phone | Work/Cell Phone | E-Mail | | |
| Address | City | State | Zip Code | |
| School | Grade | Medical Dr | | |
| Phone # | Medical Insurance Co. | | | |
| Name of Policy Holder | ID # | Grp # | | |
| Co-pay for In-Network Office: regular<br>$ | Co-pay for In-Network Office: specialist<br>$ | Policyholder's Place of Employment | | |
| Policyholder's Job Title | Policyholder's Birthdate (MM / DD / YYYY) | Yearly deductible met?<br>☐ Yes ☐ No | | |
| HSA insurance acct?<br>☐ Yes ☐ No | High Deductible ($1000 or more)?<br>☐ Yes ☐ No | 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) | ☐ 8. Loses place often when reading | ☐ 15. Covers or closes one eye |
| ☐ 2. Blurred vision (near) | ☐ 9. Repeatedly omits "small" words | ☐ 16. Tilts/turns head to one side |
| ☐ 3. Headaches | ☐ 10. Skips or rereads words/lines | ☐ 17. Moves head when reading |
| ☐ 4. Avoids close work | ☐ 11. Uses finger/marker to keep place | ☐ 18. Mistakes words with similar beginnings or endings |
| ☐ 5. Squints to see blackboard | ☐ 12. Poor reading comprehension | ☐ 19. Complains of letters/lines "floating", "running together" or "jumping" |
| ☐ 6. Fatigues easily during visual tasks | ☐ 13. Complains of seeing double | |
| ☐ 7. Frequent eye rubbing or blinking | ☐ 14. One eye turns (in, out, up or down) | |

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

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

## V. Birth History

Was birth on time? ☐ Yes ☐ No ☐ premature ☐ late

| Birth weight (lbs.) | Birth weight (oz.) |
|---|---|
| | |

Complications during pregnancy? ☐ Yes ☐ No

| Describe |
|---|
| |

Did smoking occur during pregnancy? ☐ Yes ☐ No

Did alcohol consumption occur during pregnancy? ☐ Yes ☐ No

Were forceps used? ☐ Yes ☐ No

| 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. | ☐ | ☐ | ☐ | |

| | Norm | Early | Average | Slow | Comments: |
|---|---|---|---|---|---|
| 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/Immunologic | ☐ | ☐ | |
| ADD/ADHD | ☐ | ☐ | | Genitourinary | ☐ | ☐ | | | | | |
| Asthma/Respiratory | ☐ | ☐ | | Musculoskeletal | ☐ | ☐ | | | | | |
| Cardiovascular | ☐ | ☐ | | Integumentary (skin) | ☐ | ☐ | | | | | |
| Diabetes/Endocrine | ☐ | ☐ | | Psychiatric | ☐ | ☐ | | | | | |

Other

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? | ☐ | ☐ | Wears hearing aids? | ☐ | ☐ |

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:

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

| Other |
|---|
| |

## XIV. Other

Please use the following scale to rate each:

| | None | Mild | Moderate | | Severe | | None | Mild | Moderate | | Severe |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Circle one number* | **0** | **1** | **2** | **3** | **4** | *Circle one number* | **0** | **1** | **2** | **3** | **4** |
| Headache | 0 | 1 | 2 | 3 | 4 | Difficulty concentrating | 0 | 1 | 2 | 3 | 4 |
| Nausea | 0 | 1 | 2 | 3 | 4 | Feeling mentally foggy | 0 | 1 | 2 | 3 | 4 |
| Vomiting | 0 | 1 | 2 | 3 | 4 | Difficulty remembering | 0 | 1 | 2 | 3 | 4 |
| Sensitivity to light | 0 | 1 | 2 | 3 | 4 | Attention difficulty | 0 | 1 | 2 | 3 | 4 |
| Sensitivity to noise | 0 | 1 | 2 | 3 | 4 | Feeling slowed down | 0 | 1 | 2 | 3 | 4 |
| Visual Problems | 0 | 1 | 2 | 3 | 4 | Sadness/hopelessness | 0 | 1 | 2 | 3 | 4 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | Nervous/anxious | 0 | 1 | 2 | 3 | 4 |
| Lightheadedness | 0 | 1 | 2 | 3 | 4 | Irritability | 0 | 1 | 2 | 3 | 4 |
| Balance problems | 0 | 1 | 2 | 3 | 4 | More emotional | 0 | 1 | 2 | 3 | 4 |
| Numbness/tingling | 0 | 1 | 2 | 3 | 4 | Motion sensitivity | 0 | 1 | 2 | 3 | 4 |
| Fatigue | 0 | 1 | 2 | 3 | 4 | Ruminating thoughts | 0 | 1 | 2 | 3 | 4 |
| Trouble falling asleep | 0 | 1 | 2 | 3 | 4 | Difficulty in Math | 0 | 1 | 2 | 3 | 4 |
| Sleeping more than usual | 0 | 1 | 2 | 3 | 4 | Difficulty reading | 0 | 1 | 2 | 3 | 4 |
| Sleeping less than usual | 0 | 1 | 2 | 3 | 4 | Symptoms worse at end of day | 0 | 1 | 2 | 3 | 4 |
| Drowsiness | 0 | 1 | 2 | 3 | 4 | | | | | | |

## 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 _____