

Dear Parent,

Welcome to our office. The following note and enclosed material will be helpful to understand how your child's visual system relates to school performance.

Dr. Renner and Dr. Perry will be giving an informal lecture in our office on \_\_\_\_\_ at 7:00 PM. Basic information regarding vision and learning, as well as the tests to be performed on your child, will be discussed. There will be a question and answer period at the end of the evening. We will provide an information packet with handouts on vision and learning.

We invite you to bring along your child's teacher, tutor, or other interested persons. There is no fee for this lecture. We will contact you prior to the lecture night to get an accurate number of persons for seating. Light refreshments will be available.

Dr. Renner has been working with children having visual input and processing issues for many years. Dr. Perry has recently graduated with a special interest in these areas as he used to suffer from them. Please complete the attached questionnaire and bring it with you to the appointment (not the lecture).

Our office hours are from 9:00 AM to 6:00 PM, Monday through Friday, and 9:00 to 1:00 on Saturday. The developmental vision examination will take approximately one and a half hours. The fee for the evaluation is \$310.00. A written report will be provided at the conclusion of the examination to review our discussion, test results, and recommendations.

Thank you for calling this office. We look forward to working with you.

Sincerely,

Christopher Renner, O.D.

** 48 hours notice is required for all appointment cancellations and rescheduling or a \$75.00 fee will be assessed **
--

W. Dodge Perry, O.D.

Dr. Rinearson

Dr. Renner

Dr. Warren

Dr. Perry

Name \_\_\_\_\_ Sex **M** **F** SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_ Phone (c) \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status: **Single** **Married** **Widow** **Divorced** Student Retired Employed(\_\_\_\_ PT\_\_\_\_ FT)

Referred by \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_ SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Address, if different from patient \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient: **Self** **Parent** **Spouse** **Other** \_\_\_\_\_

Other emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Payment today will be made by:** **Cash** **Check** **MasterCard** **Visa** **Discover** **American Express**

**INSURANCE INFORMATION**

Please present your insurance card(s) to the receptionist.

**Primary Insurance**

Company \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ to insured: **Self** **Spouse** **Child** **Other** \_\_\_\_\_

Subscriber's name (if different from yours) \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Birthdate \_\_\_\_\_

**Secondary Insurance**

Company \_\_\_\_\_  
Name \_\_\_\_\_

Subscriber's name (if different from yours) \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Birthdate \_\_\_\_\_

## PATIENT AUTHORIZATION

I understand that I am responsible for total payment of services rendered to me, except services covered by insurance companies with which the office has a participating agreement. I authorize the office to apply for benefits on my behalf for covered services from these plans and/or Medicare, and that payment be made directly to the office. I understand, although I might be covered under a medical insurance policy, I am primarily responsible for payment of any charges due.

I further understand that I may require a referral depending upon my insurance plan in order for services to be covered in this office. If I do not bring a referral I understand that I am responsible for all charges incurred at this office.

The **refraction and any contact lens portion** is often not a covered service but is necessary to determine the prescription for glasses or to monitor medical and surgical treatment. I will be responsible for these fees if they are not covered by my insurance plan.

I understand that if payment is not received within 90 days of the date of service, from me or my insurance company, the account will be turned over to a collection agency. I understand that if I agree to make monthly payments and the account becomes delinquent for 90 days, it will be turned over to a collection agency. I understand that if I have borrowed equipment, glasses, contacts or other materials from the office that I am responsible for returning them in good condition or I will be charged the full amount for these items. There will be an administrative charge of \$50.00 added to the balance of any unpaid portion of the bill for any account turned over to the collection agency.

I certify that the information provided on this sheet is correct and I authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by me, in writing, at any time.

I have received a copy of the office privacy practices.

\_\_\_\_\_  
Signature of patient/parent or guardian

\_\_\_\_\_  
Date

**Robin Rinearson, O.D. Christopher Renner, O.D.**  
**Robert Warren, O.D. W. Dodge Perry O.D.**  
5653 Columbia Pike  
Bailey's Crossroads, VA 22041  
703-578-3600

**\*You may refuse to sign this acknowledgment\***

I, \_\_\_\_\_, have received a copy  
of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**For office use only**  
\_\_\_\_\_

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited us from obtaining acknowledgment
- Other (Please specify)

\_\_\_\_\_ Employee signature

## Vision - History Report Form

To the Parents of (Full Name): \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Evening Phone Number: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_

### A. Present Situation:

1. In your opinion, what is your/your child's problem? \_\_\_\_\_

\_\_\_\_\_

2. How do you/your child indicate this problem? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### B. School:

1. Age at time of entrance: Kindergarten: \_\_\_\_\_ First grade: \_\_\_\_\_

2. Has a grade been repeated? \_\_\_\_\_ Which? \_\_\_\_\_

3. Have you or your child required additional help with academics? \_\_\_\_\_

**\*Note: describe all that apply**

a. More time & attention from parent \_\_\_\_\_

b. Tutor (After School \_\_\_\_\_ Summer \_\_\_\_\_)

c. Summer School \_\_\_\_\_

d. Resource Program \_\_\_\_\_

e. Learning Disability self contained program \_\_\_\_\_

f. Emotionally Disturbed Program \_\_\_\_\_

g. Language Delay Program \_\_\_\_\_

h. Multiple Mental & Physical handicap program \_\_\_\_\_

i. Gifted and Accelerated Program \_\_\_\_\_

4. School work:

Above Average    Average    Below Average    Little or No Effort

**\*Check/Describe all that apply**

Works hard but only in small groups/one on one \_\_\_\_\_

Cannot attend to tasks appropriately for age \_\_\_\_\_

Works hard but independently \_\_\_\_\_

Cannot attend to task appropriately for age \_\_\_\_\_

5. Are there any subjects or activities which seem particularly **easy**? (List them)

\_\_\_\_\_  
\_\_\_\_\_

6. Are there any subjects or activities which seem particularly **difficult**? (List them)

\_\_\_\_\_  
\_\_\_\_\_

C. Developmental History:

1. Adopted \_\_\_\_\_

2. Pregnancy: Full Term    Premature    Late  
Any illnesses, injuries or substance abuse by mother during pregnancy?  
(Please explain) \_\_\_\_\_

3. Birth: Normal Birth    Forceps    C- Section  
Birth weight \_\_\_\_\_

4. Was there any fetal distress during labor or shortly after birth? \_\_\_\_\_  
Breathing difficulty \_\_\_\_\_  
Low APGAR score \_\_\_\_\_  
Jaundice or high bilirubin \_\_\_\_\_  
Umbilical cord knotted, twisted or wrapped around neck \_\_\_\_\_  
Twin or other multiple birth \_\_\_\_\_

5. Were there any early feeding problems? Any food sensitivities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Were there any head injuries (any age)? Please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Did you/your child crawl? \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_  
Cruise furniture? \_\_\_\_\_ Age \_\_\_\_\_  
Walk \_\_\_\_\_ Age \_\_\_\_\_

8. Speech: First words \_\_\_\_\_ Age \_\_\_\_\_  
Sentences \_\_\_\_\_ Age \_\_\_\_\_  
When was speech clear to other people? \_\_\_\_\_

9. Early fine motor skills: **List age** when possible, note items not attempted yet and note items attempted without success.

Grasp in one hand \_\_\_\_\_

Transfer item from one hand to the other \_\_\_\_\_

Color: Scribble \_\_\_\_\_

Stay within lines \_\_\_\_\_

Use one color \_\_\_\_\_

Changes color to show more detail \_\_\_\_\_

A. Draw/write: Name: First \_\_\_\_\_ Last \_\_\_\_\_  
Alphabet \_\_\_\_\_  
Numbers \_\_\_\_\_  
Simple geometric figures (line, square, circle) \_\_\_\_\_  
Identifiable pictures (person, pet, scene) \_\_\_\_\_

B. Use scissors: Tears paper \_\_\_\_\_ Stays on or close to line \_\_\_\_\_  
Match two same items: (ball to ball) \_\_\_\_\_  
Match item to letter: (ball to "b") \_\_\_\_\_  
Match item to object: (ball to bat) \_\_\_\_\_

C. Complete Puzzles:  
Large wooden piece (fewer than 12 pieces) \_\_\_\_\_  
Medium (12-25 pieces) \_\_\_\_\_  
Small (more than 25 pieces) \_\_\_\_\_  
Can child use strategy to complete these? (borders, colors, shapes)  
\_\_\_\_\_  
Refuses to do this activity \_\_\_\_\_  
Are pieces easily positioned? \_\_\_\_\_  
Mashed into place \_\_\_\_\_

D. Dressing Skills:  
Button \_\_\_\_\_ Watch for tags \_\_\_\_\_  
Snap \_\_\_\_\_ Put shoes on correctly \_\_\_\_\_  
Tie \_\_\_\_\_ Buckle \_\_\_\_\_  
Zip (pants) \_\_\_\_\_ Zip (start jackets) \_\_\_\_\_

10. Gross Motor Skills:  
Run \_\_\_\_\_ Skip \_\_\_\_\_ Hop on one foot \_\_\_\_\_  
Jump \_\_\_\_\_ Balance on one foot \_\_\_\_\_  
Throw ball accurately \_\_\_\_\_ Grasp catch (two hands, on body) \_\_\_\_\_  
Two hand catch \_\_\_\_\_ One hand (reach) catch \_\_\_\_\_  
Kick ball (not in motion) \_\_\_\_\_ In motion \_\_\_\_\_  
Climb on jungle gyms, overhead ladder or monkey bars \_\_\_\_\_  
Pedal a bigwheel \_\_\_\_\_ Tricycle \_\_\_\_\_  
Bicycle with training wheels \_\_\_\_\_ 2-wheeler \_\_\_\_\_  
Roller skate, skateboard, ice skate, ski or water ski \_\_\_\_\_  
Any sports participation? Please list \_\_\_\_\_

Aiming: darts, shooting, bow & arrow, billiards, basketball \_\_\_\_\_

11. Are there any special talents? singing, dancing, musical instruments, drawing, etc.

\_\_\_\_\_

12. Are you/your child easily distracted or inattentive to tasks? Even when you're very interested? \_\_\_\_\_

Have you/your child had behavioral counseling? \_\_\_\_\_

Have you/your child had trial periods with medications like ritalin, cylert, antihistamines, vitamins to assist with attention span? \_\_\_\_\_

What happened? \_\_\_\_\_

#### D. Medical History

1. Are there any inherited disorders known to be present in you/your child?  
(Down Syndrome, PKU, Marfan's, Huntington's Chorea, etc.) \_\_\_\_\_

2. Are there any known physical problems? muscular, cardiovascular, intestinal, neurological, visual: \_\_\_\_\_

3. List all allergies to foods/medications \_\_\_\_\_

4. List all surgical procedures \_\_\_\_\_

5. Vision:

Previous examination date \_\_\_\_\_ Name of doctor \_\_\_\_\_

Were new lenses prescribed? \_\_\_\_\_

How long have lenses been worn? \_\_\_\_\_

Was patching or vision therapy recommended \_\_\_\_\_

If so, was the procedure completed? \_\_\_\_\_

List any surgery to eyes (include laser) \_\_\_\_\_

Do you/your child have contact lenses? \_\_\_\_\_

Any problems associated with lens wear or solutions? \_\_\_\_\_

6. Headaches:

How often (times per week or month)? \_\_\_\_\_

How long do they last? \_\_\_\_\_

Does aspirin, tylenol, or other medication help? \_\_\_\_\_

List any special medication (fiorinal, demerol, codeine, caffergot) \_\_\_\_\_

When do they start? (Check all that apply) Check if no pattern is noted \_\_\_\_\_

Early in morning \_\_\_\_\_

Mid-Day \_\_\_\_\_

Late-Day \_\_\_\_\_

Related to close work \_\_\_\_\_

After consuming certain foods \_\_\_\_\_

Without eating \_\_\_\_\_

Related to seasonal allergy \_\_\_\_\_

Other \_\_\_\_\_

Where does it hurt?  
 All over \_\_\_\_\_ Top of head \_\_\_\_\_  
 Temples \_\_\_\_\_ Neck or base of head \_\_\_\_\_  
 Forehead \_\_\_\_\_ In or between the eyes or one eye \_\_\_\_\_  
 One side \_\_\_\_\_  
 Same side all the time? \_\_\_\_\_

Describe type of pain:  
 Dull ache or throb \_\_\_\_\_  
 Squeezing \_\_\_\_\_  
 Sharp, stabbing, or pulsating \_\_\_\_\_  
 Pressure \_\_\_\_\_  
 Other \_\_\_\_\_

Do you have any of these symptoms before or during the headache?  
 Strange colors \_\_\_\_\_  
 Flashing Zig-Zags or twinkles of lights \_\_\_\_\_  
 Double vision \_\_\_\_\_  
 Part of vision missing \_\_\_\_\_  
 Strange smell \_\_\_\_\_  
 Strange taste in mouth \_\_\_\_\_  
 Strange feeling in stomach or vomiting \_\_\_\_\_  
 Sensitivity to light \_\_\_\_\_  
 Hot or cold sweats \_\_\_\_\_  
 Numbness or tingling in hands, feet, etc. \_\_\_\_\_

Have you/your child had a neurological examination? \_\_\_\_\_  
 Do you/your child have a seizure disorder? \_\_\_\_\_

7. Family History - List brothers, sister, parents, grandparents, aunts & uncles (blood relatives)

High blood pressure \_\_\_\_\_  
 Diabetes: Juvenile \_\_\_\_\_ Late Age \_\_\_\_\_  
 Stroke \_\_\_\_\_ Kidney Disorder \_\_\_\_\_  
 Heart problems (include murmur, by-pass, pacemaker, valve problems, holes in heart) \_\_\_\_\_  
 Cancer \_\_\_\_\_ Thyroid Problems \_\_\_\_\_  
 Metabolic disorders \_\_\_\_\_ Glaucoma \_\_\_\_\_  
 Cataracts \_\_\_\_\_ Blindness \_\_\_\_\_  
 Lazy eye (strabismus, amblyopia) \_\_\_\_\_  
 Other \_\_\_\_\_

8. Please bring any results of academic/psychological test batteries performed and recommendations.

9. List any other pertinent information or comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Speech/Language Check List

Yes

No

- Child experiences frustration in communicating
- Child is not understood by strangers (by age 3)
- There is a significant history of middle ear difficulties
- Child's vocabulary does not match that of peers
- Child is not able to follow multiple step directions
- Child avoids use of telephone
- Child does not use specific names for people, place, and things
- Child has difficulty learning categories
- Child uses awkward sentence structures
- Child's expressive language is characterized by notable hesitations and false starts
- Child appears to miss critical pieces of information in general conversation
- Child is not able to relate a story in style commensurate with peers
- Child experiences difficulty in communicating needs, ideas, and feelings
- Child does not read voluntarily
- Child is not able to retain spelling words
- Child's writing abilities are not commensurate with peers and effort
- Child's school performance is not commensurate with effort and potential
- There is a history of academic difficulties in the family
- Child does not understand and tell jokes

“Yes” responses suggest Language Dysfunction

EDUCATOR'S CHECKLIST -  
OBSERVABLE CLUES TO CLASSROOM VISION PROBLEMS

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

1. Appearance of Eyes:

One eye turns in or out

Reddened eyes or lids

Excessive tearing

Encrusted eyelids

Frequent styes

Other (Please describe) \_\_\_\_\_

2. Complaints when Using Eyes at Desk:

Headaches

Nausea or dizziness

Eyes burn or itch after reading or seat work

Print blurs after reading a short time

Other (Please describe) \_\_\_\_\_

3. Behavioral Signs of Visual Problems:

A. Eye Movement Abilities (Ocular Motility)

Head turns when reading across page

Loses place often during reading

Needs finger or marker to keep place

Displays short attention span while reading  
or copying

Too frequently omits words

Re-reads, skips lines

Orients drawings poorly on page

B. Eye Teaming Abilities (Binocularity)

Complains about seeing double

Repeats letters within words

Omits letters, numbers or phrases

Misaligns digits in columns  
Squints, closes, covers one eye  
Tilts head, lays on one arm at desk or table,  
    lays on stomach to read or stands beside desk  
Wiggles in chair, moves papers, re-adjusts books  
    constantly

C. Eye-hand Coordination Abilities

Must feel things to assist in any interpretation  
    required

Eyes not used to steer things:

    Spills or knocks things over  
    Can't orient or align items on paper  
    Can't thread needles, tie, start zippers

Writes crookedly, poorly spaced, cannot stay in  
    ruled lines

Misaligns both horizontal and vertical series of  
    numbers

Uses hand or fingers to keep place on the page

Uses other hand as spacer to control spacing  
    and alignment on the page

Confuses right and left

D. Visual Form Perception (Visual Comparison, Imagery Visualization)

Mistakes words with same or similar beginnings

Fails to recognize same word in same sentence  
    and/or next paragraph

Reverses letters and/or words in writing and  
    copying

Repeatedly confuses similar beginnings and  
    endings on words

Fails to visualize what is read either silently  
    or orally

Whispers to self for reinforcement while reading  
    silently

Returns to "drawing with fingers" to decide  
    likes and differences

E. Refractive Status (Nearsightedness, Farsightedness, Focus Problems, etc.)

Comprehension reduces as reading continues,  
loses interest too quickly

Mispronounces similar words as reading  
continues

Blinks excessively at desk tasks and/or while  
reading but not elsewhere

Holds book too closely, face too close to desk  
surface

Avoids all possible near-centered tasks

Complains of discomfort in tasks that demand  
visual interpretation

Closes or covers one eye when reading or doing  
homework

Makes errors in copying from reference books to  
notebook

Squints to see chalkboard, or requests to move  
closer

Rubs eyes during or after short periods of visual  
activity

Fatigues easily