TENNESSEE VISION THERAPY

The following information will help prepare your child for the upcoming appointment at our office. Your timely completion of these forms will allow us the needed time to process and review your case in advance. We ask that every page be filled out in its entirety and all pertinent medical records including the most recent eye exam are returned to our office **at least two business days prior to the scheduled evaluation**.

What is a Developmental Vision Evaluation?

A Developmental Vision Evaluation includes checking the general health of the eye, visual acuity (20/20), refractive condition for appropriate corrective lenses when needed and all of the visual functions required for reading, writing, learning, sports performance and functioning in life. A developmental vision evaluation helps to pinpoint the precise area(s) of concern as well as the depth of the problem and to determine the best treatment options.

What tests are performed?

Sensorimotor Testing- measures ocular motility, ocular alignment, and ocular deviation in more than one area of gaze and binocular fusion. It is necessary for detection, assessment, monitoring and guidance for the medical, surgical and optical management of binocular function and motor eye misalignment.

Visual Perceptual Testing- tests the brain's ability to make sense of what the eyes see. It is important for everyday activities such as dressing, eating, writing, and playing. When a child is behind in the development of visual processing skills, learning can take longer, requiring more cognitive effort that slows down the learning process. **Our standard battery of tests may not be applicable to your child due to age. The doctor may modify testing to better suit your child. **

How long does the testing take?

Testing takes approximately 2 hours and is scheduled in the morning before the eyes and brain are tired from a full day of school. We also like to do testing at this time so your child has eaten a good, high protein meal and is most attentive. We try our best to fully engage your child and to make it as fun as possible.

Who can come to the appointment?

Because full attention is needed, it is very important that you **do not bring any additional family members such as siblings to the evaluation**. We ask that only the patient and parents. This minimizes distraction and enhances the productivity of the time spent in our office.

What is my financial policy?

Third parties, such as medical insurance, Medicare and TennCare, severely limit treatment, care options, and the time the Doctor and team can spend with you. Therefore, Tennessee Vision Therapy is a fee-for-service facility and payment is due in full at the time of service. The total cost of the Initial Visit is $350, which includes the evaluation,testing, consultation, and a follow-up summary of the Doctor's findings.

Will I get the results the same day?

Yes! During your consultation all the findings will be explained to you and literature will be provided. The recommendations from the Doctor, how to proceed and expectations will also be explained.

We look forward to meeting you and your child! If you have any additional questions, please feel free to contact us.

Tennessee Vision Therapy
3252 Aspen Grove Dr., Ste.7
Franklin, TN 37067
P: 615-791-5766 or 615-905-4668

Infant/Toddler/Preschool
Medical & Vision History Form

Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.

Patient's Full Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Gender: Male or Female

Address: _____ City: _____ Zip:_____

Name of Daycare or Preschool: _____

HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business _____

Internet: Which terms did you search? Vision Therapy Lazy Eye Crossed Eye ADHD Learning Disabilities Convergence Autism Tracking Issues Reading Issues

Current/Previous Patient: _____

CONTACT INFORMATION

Mother/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

Father/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

Reason for today's visit: _____

CHILD'S MEDICAL HISTORY: *Please fully complete*

Pediatrician: _____ Date of Last Visit: _____

Practice Name: _____

Current Medications (include vitamins/supplements): _____

_____

Is your child allergic to any medications? If yes, please list or circle **No Know Drug Allergies**

_____

Did your child receive immunizations? *Yes* or *No*

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PREGNANCY/BIRTHING HISTORY

Length of pregnancy: _____ wks My child is: Natural Adopted Foster Other

Is medical history known? Yes No

During pregnancy of this child, which, if any, of the following occurred? *Circle all that apply*

Toxemia	Fall	COVID	Preeclampsia	Placental Abruption
Trauma	Smoking	Measles	Chicken Pox	Umbilical Cord Prolapse
Epstein-Barr	Zika	STD	Toxoplasmosis	Prolonged Labor
Low Oxygen	Hepatitis	Anemia	Use of Drugs/Alcohol	Maternal Diabetes

Type of delivery: Natural Cesarean Forceps/Vacuum Anesthesia Nubian Epidural

Delivery complications: _____

Labor lasted: _____ hrs Child's birth weight: _____ Mother's age @ delivery: _____

Apgar score @ 1 min: _____ @ 5 mins: _____ Father's age @ delivery: _____

Immediately after giving birth my child had or was:

Low Birth Weight	Anemia	Respiratory Distress	Doing Well
A fever	Rh Problems	Feeding Problems	Placed in incubator
Allergic Reaction	Jaundice	Birth Defect	Placed in NICU

CHILD'S FAMILY & HOME

Are there others living in your home? ☐ No ☐ Yes Please list names, ages, and relation below:

_____

_____

Does your child spend a significant amount of time with any other person not in the home?

Please explain: _____

Has your child ever been through a traumatic situation (separation, divorce, loss, abuse, etc.)?

At what age & please explain: _____

What percentage of the waking hours is/was your child in a: baby swing _____ playpen _____ walker _____ seat _____ crib _____

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CHILD'S DEVELOPMENTAL HISTORY

	Avg. Age	Early	Late	Normal	Unsure
Eye Control	3 months				
Rolled over	3-4 months				
Reaches/grasps for objects	4 months				
Responds to words or name	5 months				
Sits w/o support	6.5 months				
Crawl (stomach on floor)	7 months				
Creep (stomach off floor)	8 months				
Pulls self to stand	8 months				
Nice pincher grasp	11 months				
Walks unaided/alone	12 months				
Walks backwards	14 months				
Scribbles spontaneously	15 months				
Kicks a ball	18 months				
Walks up steps with help	18 months				
Stacks/piles blocks	18 months				
Eats with fork/spoon	24 months				
Toilet trained	2.5 years				
Puts on some clothes alone	3 years				
Rides tricycle	3 years				
Copies a circle	3 years				
Can match objects	3 years				
Names body parts	3 years				
Identifies 5-6 colors	4 years				
Copies a square	4 years				
Cuts a circle with scissors	4 years				
Hops on 1 foot	4 years				
Can point to letters/numbers when named	4 years				
Knows same/different	4 years				
Writes first name	5 years				

Infant/Toddler/Preschool
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Reads 25 words	5 years				
Identifies right & left on self	5 years				

CHILD'S VISUAL & BEHAVIORAL HISTORY: *please fully complete*

Visual	**Y**	**N**	**Behavioral & Mental**	**Y**	**N**
Eye turns in/out			Lack of curiosity		
Squints while looking at objects			Hyperactive, high energy		
Covers/closes one eye a lot			Separation anxiety		
Doesn't seem to focus			Thumb sucking		
Lacks interest in objects			Passive		
Rubs eyes excessively			Sleeplessness		
Reddened or encrusted eye(s)			Nervous		
Blinks excessively			Easily upset		
Eyes in constant motion			Lethargic, low energy		
Watery eyes			Sulky, moody		
Eyelid droop			Restlessness		
Poor tracking/eye movements			Aggressive		
Is abnormally bothered by bright lights			Defiant		
Seems visually unaware			Bed wetting		
Stares at bright lights			Autism Spectrum		
Repeatedly flicks objects in front of face			Panics easily		
Turns head to only use one eye			Compulsive tendencies		
Head tilt/face turn			Eating disorder/problems		
Moves objects very close to look at them			Speech/language delay		
Stumbles over objects or is clumsy			Social phobia		
Poor motor control			Sensory processing disorder		
Unable to see distant objects			Executive functioning disorder		
Unable to transfer from hand to hand			Disruptive		
Unable to stack blocks			Self-harm		
Eye injury or surgery			Dyslexic tendencies		
Amblyopia or lazy eye			Wants to hurt others		
Patching			Temper tantrums		
Vision Therapy/Orthoptics			Intellectually above peers		

Infant/Toddler/Preschool
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Complains about his/her vision			Intellectually below peers		

Was there ever any reason for concern with your child's general growth and development during the first year of life? No Yes Explain: _____

_____

Has the Pediatrician or other specialist ever mentioned a concern with primitive reflexes? _____

Has your child been diagnosed with developmental delay, chromosomal abnormality, and/or genetic disorder? No Yes, explain: _____

Does your child sleep through the night? _____ How many hrs? ____ Starting at what age: ___

Has your child had a therapy evaluation at any of the following: circle all that apply

OT PT Speech Audiology Feeding ABA Play Music Animal Assisted

FAMILY HISTORY ***(Please check if there is any history of the following.)***

	N	Y	Family Member		N	Y	Family Member
Poor Vision/ High Rx/Myopia				High Blood Pressure			
Strabismus/Eye Turn				Epilepsy or Seizures			
Amblyopia (lazy eye)				Diabetes			
Blindness				Thyroid			
Glaucoma				Cancer			

What are your biggest concerns regarding your child at this time? _____

_____

_____

I hereby give my permission to Tennessee Vision Therapy to treat:

_____

Patient's Name

_____ _____

Patient, Parent, or Guardian's Signature Date

Infant/Toddler/Preschool
Medical & Vision History Form

Release of information:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your child's care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to myself or my child's other health care providers upon their written request or upon the recommendation of Tennessee Vision Therapy when it is necessary for the treatment of my child's visual condition. I authorize Tennessee Vision Therapy Group, and their staff to exchange information with other professionals involved in my child's care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
Signature Date

_____
Relationship to patient

Release of Information to Non-Medical Staff/Family Members

I, _____, give permission for Tennessee Vision Therapy to release medical information to the following non-medical individual(s)- teachers, tutors, coaches.

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

Name: _____ Relationship to patient: _____

Phone Number: _____ Email: _____

_____ _____
Signature Date

_____
Relationship to patient

Infant/Toddler/Preschool
Medical & Vision History Form

Patient Photo and Video Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information.

This release is strictly designed to give permission to Tennessee Vision Therapy, to use my digital patient photos and/or video for their website, social media, and in office presentation for both educational and promotional purposes. Our providers and staff will have permission to use these photos in the manner discussed with me, unless I request the office no longer use them. I understand that by allowing Tennessee Vision Therapy to use my photos, I am expressing consent to share images publicly to educate and explain procedures and results of therapy. I understand that I have the option to decline this request and am not obligated in any way to provide permission to use these photos.

Please check appropriate box:

- ☐ I will allow Tennessee Vision Therapy to share my digital patient photos, recorded videos, and my written success story/testimonial.
- ☐ I am requesting that none of my information be shared publicly.

Patient Name: _____

Printed Parent Name: _____

Signature: _____ Date:_____

Office Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physician and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time with your new patient paperwork completed. As a courtesy, and to help patients remember their scheduled appointments, we send a confirmation email after scheduling and a reminder call a few days prior to your appointment. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.