

Please provide the following information as completely as possible.

Child's Name: _____ Date of Birth _____

Address: _____

Phone Numbers:

Home _____ Work _____ Cell _____

Email _____

Parent(s) Name: _____ Occupation: _____

Name of School: _____ Grade: _____

Address: _____

FAX # _____ Teacher's Name: _____

Referred By: _____

(or) How Did You Hear About Dr. Frenkel? _____

HeartLight Healing Arts
9145 Guilford Road, Suite 100
Columbia, MD 21046

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of HeartLight
(Patient Name) Healing Arts' Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date

Acceptable Methods of Disclosure
of Protected Health Information

How would you like to be contacted re: answers to questions, lab requests, etc.?
(Please check ALL that apply)

_____ Home Phone: _____
_____ Work Phone: _____
_____ Cell Phone: _____
_____ FAX: _____
_____ Other: Please specify _____

If we are unable to reach you, should we leave a message to include protected health information?

_____ Yes _____ No

If so, where should we the leave the information?
(Please check ALL that apply)

_____ Home Phone
_____ Work Phone
_____ Cell Phone
_____ Leave a message with spouse or significant other
_____ Other: Please specify _____

Signature of Patient or Legal Guardian

Date

WELCOME TO
HeartLight Healing Arts
9145 Guilford Road – Suite 100
Columbia, MD 21046

Dr. Debra Frenkel, Developmental/Behavioral Optometrist, is looking forward to providing your child with high quality personalized care. Your appointment time is reserved specifically for you. We do not overbook in anticipation of a cancellation or no-show. The doctor's emphasis is to maximize success for your child.

PLEASE FILL OUT THE ENCLOSED HISTORY FORM and mail it to us along with this form. Copies of previous evaluations and reports may be included in your mailing or you may bring them with you.

Please bring any eyeglasses and/or contact lenses (and the contact lens prescription) with you.

PAYMENT POLICY

In order to provide this high quality personalized service, we are not affiliated with any insurance plan and provide service on a private pay basis only. Payment for the balance of the evaluation fee will be expected in full at the time of service. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt/invoice to submit to your insurance company.

I have read and fully understand and accept these policies.

Signature: _____

Date _____

I look forward to meeting you on: _____

Please bring this form with you.

Dr. Debra Frenkel
9145 Guilford Road, Suite 100
Columbia, MD 20146

DEVELOPMENTAL/BEHAVIORAL OPTOMETRIST

SPECIALIZING IN DEVELOPMENTAL AND LEARNING RELATED VISION PROBLEMS

The reason my child is being examined is general check up other, please explain:

When did symptoms start: _____

Last eye exam was on _____ Where: _____

Glasses: Y / N - Age 1st Worn _____

Does your child have any of the following: Explain

Eye turns in/out	Y	N	_____
Squints a lot	Y	N	_____
Covers/closes one eye a lot	Y	N	_____
Doesn't seem to focus	Y	N	_____
Lacks interest in looking at objects	Y	N	_____
Rubs eyes excessively	Y	N	_____
Eyes burn and itch	Y	N	_____
Reddened or encrusted eyelids	Y	N	_____
Blinks excessively	Y	N	_____
Watery eyes	Y	N	_____
Eyelid Droop	Y	N	_____
Poor tracking/eye movements	Y	N	_____
Head tilt/Face turn	Y	N	_____
Moves objects very close to look	Y	N	_____
Double vision	Y	N	_____
Frequent headaches	Y	N	_____
Eye pain	Y	N	_____
Excess light sensitivity	Y	N	_____
Stares at bright lights or repeatedly flicks objects in front of face	Y	N	_____
Stumbles over objects or is clumsy	Y	N	_____
Poor motor control	Y	N	_____
Any eye injury or surgery	Y	N	_____

Any lazy eye/amblyopia	Y	N	_____
Any patching	Y	N	_____
Any vision therapy/orthoptics	Y	N	_____

Does your child verbalize any problems/ complaints about his/her eyes or vision? Y / N

If yes, explain: _____

Last medical exam was on _____ Doctor: _____

Current medications (dose & reason for taking) _____

Immunizations up to date: Y / N Any Reactions to Immunizations: _____

Medical History _____ Explain

Does your child have or has your child had:

Allergies/ allergies to medicines Y N _____

Surgery/hospitalizations Y N _____

Cardiovascular/heart problems Y N _____

High blood pressure, murmur, other

Breathing problems Y N _____

Asthma, shortness of breath, other

Gastrointestinal problems Y N _____

Food problems, diarrhea, vomiting, other

Endocrine problems Y N _____

Diabetes, thyroid, growth, other

Urinary problems Y N _____

Pain/discomfort, blood in urine, other

Skin problems Y N _____

Unusual rashes, excess dryness, other

Musculoskeletal problems Y N _____

Juvenile Rheumatoid Arthritis, other

Neurological problems Y N _____

High fever, seizures, balance, other

Psychiatric/Social problems Y N _____

Any behavior problems, other

General growth/developmental: normal /delayed _____

Chronic fever Y N _____

Unexplained weight loss/gain Y N _____

Ear/nose/throat problems Y N _____

Hearing loss, frequent sore throats, sinus problems

Blood diseases Y N _____

Bleeding disorders, sickle cell, other

Head Injury/ Trauma Y N _____

Bad fall, loss of consciousness

Cancer, HIV virus, other medical Y N _____

conditions not noted above? Specify: _____

Fine Motor Development

EARLY LATER NORMAL UNSURE

1. Eye control 180 degrees	3 Months	_____	_____	_____	_____
2. Reaches/Grasp for object	4 Months	_____	_____	_____	_____
3. Scribbles spontaneously	15 Months	_____	_____	_____	_____
4. Stacks/Piles blocks	18 Months	_____	_____	_____	_____
5. Eats with a fork/spoon	24 Months	_____	_____	_____	_____
6. Copies circle	3 years	_____	_____	_____	_____

Language Development AVERAGE AGE

EARLY LATER NORMAL UNSURE

1. Smiles spontaneously	1 Month	_____	_____	_____	_____
2. Responsive smile	3-4 Months	_____	_____	_____	_____
3. Responds to words/ names	5 Months	_____	_____	_____	_____
4. Says single words	12 Months	_____	_____	_____	_____
5. Refers to self by first name	18 Months	_____	_____	_____	_____
6. Combines 2 different words	18 Months	_____	_____	_____	_____
7. Says 2 word sentences	24 Months	_____	_____	_____	_____
8. Knows full name	3 Years	_____	_____	_____	_____

How well developed is your child's spoken vocabulary? _____

How well does your child understand/respond to spoken language? _____

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting)? Yes No

If yes, explain: _____

Any problems with colic? Yes No

Was there ever any reason for concern over your child's general growth or development? Yes No

If yes, why? _____

Has your child received any special developmental guidance/ assistance? Yes No

If yes, explain: _____

How many hours daily does your child sleep? _____

Does your child sleep through the night? Yes No If yes, starting at what age: _____

If no, explain: _____

Did your child have a coordinated crawl and creep before he/she walked? Yes No

What things can your child do very well? _____

What things, if any, are difficult for your child? _____

Can your child identify colors? Yes No If yes, which? _____

Can your child identify numbers or letters? Yes No If yes, which? _____

Does your child like to draw/color? Yes No

Is your child learning to read? Yes No

Has your child undergone any of the following treatments? If currently in treatment, please indicate:

Educational	Y	N	Neurological	Y	N	Psychological	Y	N
Occupational	Y	N	Speech/Auditory	Y	N	Physical	Y	N

If yes, please list all previous evaluations done on your child:

Doctor or Institution	Date(s)	Type of Evaluation	Results/Treatment/Intervention
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	<input type="checkbox"/>	Irritable, easily upset	<input type="checkbox"/>
Thumb-sucking	<input type="checkbox"/>	Restlessness	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	Has difficulty separating from parents	<input type="checkbox"/>
Glum, sulky, moody	<input type="checkbox"/>	Sleeplessness	<input type="checkbox"/>
Bad temper	<input type="checkbox"/>	Lethargic, low energy	<input type="checkbox"/>
Passive	<input type="checkbox"/>	Aggressive	<input type="checkbox"/>

Other (please explain): _____

Nutritional Information:

Current Diet: Nursed Nursed until what age: _____ Bottle fed

Solid food started at what age: _____ What type? _____

Are there any food allergies/sensitivities? Yes No

If yes, what: _____

Activity Level: High Moderate Low

Are there periods of very high energy Yes No

Are there periods of very low energy? Yes No

Does your child: Like sweets and/or Crave sweets

If so, what? _____

What are his/her favorite foods? _____

What are his/her disliked/avoided foods? _____

Family History:

Does anyone in the family/blood relative have:

If yes, who & please explain:

Amblyopia/Lazy eye	Y	N	_____	_____
Eye Turn / Strabismus	Y	N	_____	_____
Color Vision defect	Y	N	_____	_____
Glaucoma	Y	N	_____	_____
Blindness	Y	N	_____	_____
Other eye problems/diseases	Y	N	_____	_____
High blood pressure/heart problems	Y	N	_____	_____
Diabetes	Y	N	_____	_____
Neurological disease	Y	N	_____	_____
Birth defects / Genetic disorders	Y	N	_____	_____
Cancer	Y	N	_____	_____
Thyroid conditions	Y	N	_____	_____
Multiple sclerosis	Y	N	_____	_____
Epilepsy or seizures	Y	N	_____	_____
Learning disability	Y	N	_____	_____
Other medical condition not listed above	Y	N	_____	_____

Is there any other information that would be helpful/important in our evaluation or treatment of your child?

Have you or anyone else ever noted the following:

	<u>yes</u>	<u>no</u>	<u>Comments</u>
1. Holding reading too close or further away? _____			
2. Closing or covering one eye? _____			
3. Difficulty copying from the chalkboard? _____			
4. Eyes burning, stinging, watery or reddened? _____			
5. Dizziness or nausea with near work? _____			
6. Excessive eye rubbing or blinking? _____			
7. Skips/Rereads lines or uses a marker to keep place? _____			
8. Distorted posture when reading? _____			
9. Handwriting laborious and/or hard to read? _____			
10. Inability to see distant objects? _____			
11. Bumping into objects? _____			
12. Poor general coordination? _____			
13. Inconsistent /poor sports performance? _____			
14. Vision worse at the end of the day? _____			
15. Short attention span? _____			
16. Eye fatigue, blur or other symptoms while using a computer? _____			
17. Reversing letters/words? _____			
18. Car sickness or motion sickness _____			

School:

1. Age at time of entrance? _____ Kindergarten _____ First Grade
2. Does child like school? yes_____ no_____ Teacher? yes_____ no_____
3. Has a grade been repeated? yes_____ no_____ Which grade?_____
4. Have there been any school difficulties? yes_____ no_____ If yes, please explain –

5. Is schoolwork: average_____ better than average_____ below average_____
6. Is there any subject(s) that seem particularly easy for your child? _____
7. Is there any subject(s) that seem particularly difficult? _____

Developmental history: (If for any reason this information is unknown please write NK)

1. Did your child crawl? _____ All fours _____ Age _____
2. At what age did child walk? _____
3. Age at first words? _____
4. Was child active? _____
5. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc:

6. List illnesses (especially high fevers)

7. At what age did your child lose his/her first tooth? _____

Is your child currently receiving medical care /physical therapy/occupational therapy/speech-auditory therapy/complementary(alternative) therapy for any conditions? Please list the treatment and the diagnosis. Also include any medications or remedies. If there has been previous treatment or school-based care please note that also.

Is there any history of head injury, falls, accidents or serious wounds in the head/neck/back area? If so please describe.

Visual History

1. How long has visual difficulty been noticed? _____
2. Has there been previous visual care? _____ If so, please detail below:

Doctor's Name	Approximate Date	Result (s)
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3. Please list family members who have any visual conditions, learning problems or similar medical conditions.

Name and Relationship	Age (now)	Visual, learning or medical condition and age it began (if known)
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From completing this questionnaire, you will recognize the thoroughness with which your child's problem will be considered. The office examination will allow ample time to permit a very complete optometric investigation of your child's problem. It is desirable to have both parents present during the examination. Your child's future deserves the fullest consideration that you as parents and we here in the office can provide.

Please fill out this questionnaire. Thank You.

NAME _____ DATE _____

Please assign a value between 0 and 4 for each symptom.

4=always / 3=frequently / 2=occasionally / 1=seldom / 0=never or not applicable

1	Blurred vision at (circle) near or distance or both	
2	Double vision	
3	Headaches associated with near work	
4	Words run together or jump around on the page when reading	
5	Skipping or repeating lines when reading (losing your place)	
6	Falling asleep when reading	
7	Vision worse at end of the day	
8	Burning, stinging, watery eyes	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from chalkboard/overhead material	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	When reaching for an object you knock it over or your hand misses it	
15	Misaligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Avoiding sports and games	
22	Do people or things suddenly appear from one side (that you didn't see approaching)	
23	Inability to estimate distance accurately	
24	Car sickness/ motion sickness	
25	Forgetful, poor memory	