

Stars In Your Eyes

vision training center



austinvt.com

Dr. Emily Schottman, FCOVD

Board-Certified in Vision Development & Training

2116 Hancock Drive, Austin, TX 78756

Phone: (512) 419-1212 Fax: (512) 371-0164

Email: austinvtstars@gmail.com

DEVELOPMENTAL VISION EVALUATION

Patient's Name: _____ Date of Birth: _____ Age: _____ yrs.

PATIENT VISUAL HISTORY

Why do you feel there is a need for a Visual Evaluation? _____

How long has this problem/difficulty been observed? _____

Describe how the problem hinders the patient's daily activities and life: _____

If the Patient has had Vision Therapy or Vision Training, where and when: _____

PATIENT DEVELOPMENTAL HISTORY

If any of the following evaluations been performed, check the box and describe who provided the evaluation, what the findings were, and what was recommended. **★PLEASE SEND ALL EVALUATION REPORTS TO OUR OFFICE BEFORE FIRST APPOINTMENT.**

Educational Who: _____ Findings: _____
Recommendations: _____

Neurological Who: _____ Findings: _____
Recommendations: _____

Psychological Who: _____ Findings: _____
Recommendations: _____

Occupational Who: _____ Findings: _____
Recommendations: _____

Chiropractic Who: _____ Findings: _____
Recommendations: _____

PATIENT NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Has the patient tested positive for Food Allergies? If so, which foods? _____

PATIENT FAMILY AND HOME

Please list and describe the relationship to any other adults and children the patient lives with:

Has the patient ever been through a traumatic family situation (changing schools, separation/divorce, death of a family member, illness)?

Yes No If "Yes," please explain: _____

Was counseling/therapy undertaken? Yes No If "Yes," is it on-going? Yes No

Is family life stable at this time? Yes No If "No," please explain: _____

CHILD PATIENT SCHOOL AND LEARNING ISSUES (Adult patients skip this section.)

School Name: _____ Teacher Name: _____ Current Grade: _____

In-School Educational Specialist Name: _____ Have any grades been repeated? Yes No

Specifically describe any school difficulties: _____

Which subjects are: Above average: _____
Average: _____
Below average: _____

How much time on average does your child spend each day on homework assignments? _____ hours

List hobbies/regular activities: _____

Are there activities they would like to do but can't/won't? _____

COMPUTER USE (If computers are used by patient.)

How many hours do you spend in front of a computer screen each day? _____

How long can you use a computer until your eyes bother you? _____

Where is the computer monitor located? Directly in front of you To your right To your left 2 or more monitors

Where is the top of the screen located? Above your eyes At eye level Below eye level

If you refer to documents, where are they located? To your right To your left Flat (horizontal) or vertical

What is the distance (in inches) from your eyes to the: Monitor? _____ Keyboard? _____ Any reference documents? _____

Do you notice glare/reflections from your: Monitor Windows Lighting Other _____

Do any of body parts ache/hurt after working on the computer? Neck Face Back Arm Hand Leg

Other _____ Describe the sensation. _____

Do you wear glasses or contact lenses for computer work? Glasses Contact Lenses Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

EMPLOYMENT/COLLEGE (To be completed only for adult patients.)

Current position: _____ Major course of study: _____

Describe briefly your daily activities at work or in school: _____

What are your biggest challenges with these activities? _____

How many hours daily do you spend working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes No

Do you feel an increasing need for more effort to accomplish tasks? Yes No

If "Yes," please explain: _____

PATIENT OVERVIEW

Give a brief description of the patient as a person:

What are the biggest concerns for the patient at this time?

What is your goal for the visual evaluation and/or vision training?

★ Please fax this completed form to (512) 371-0164 at least 3 business days before your appointment or your appointment will have to be rescheduled. We require a minimum of 24 hours notice if you are unable to keep this appointment. If less than 24 hours, then there is a \$45 rescheduling fee to reappoint a missed appointment. A missed initial appointment will not be rescheduled.

Stars In Your Eyes

vision training center



austinvt.com

Dr. Emily Schottman, FCOVD
Board-Certified in Vision Development & Training

2116 Hancock Drive, Austin, TX 78756

Phone: (512) 419-1212 Fax: (512) 371-0164

Email: austinvtstars@gmail.com

RELEASE OF INFORMATION

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN THE PATIENT'S CARE. PLEASE COMPLETE THIS FORM AND SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION FOR: _____.

Printed Patient Name

If you are the patient:

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the STARS IN YOUR EYES VISION TRAINING CENTER when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. I authorize Dr. Emily Schottman and STARS IN YOUR EYES VISION TRAINING CENTER to exchange information with other professionals involved in my care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

If you are the parent or guardian of the patient:

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of the STARS IN YOUR EYES VISION TRAINING CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Emily Schottman and STARS IN YOUR EYES VISION TRAINING CENTER to exchange information with my child's school and 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.

I hereby give my permission to STARS IN YOUR EYES VISION TRAINING CENTER to treat _____.

Printed Child's Name

I understand that I have the right to cancel this authorization in writing, except for disclosures made as a condition of obtaining insurance coverage or for Treatment, Payment, or Healthcare Operations for Services that have already occurred, and have been informed of how I may cancel the Authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receipt and no longer be protected by the medical privacy laws. Treatment or Payment may not be conditioned on obtaining the authorization if that is prohibited by the Privacy Rule. At your request, we will provide you with a copy of this request once this has been signed.

Signature

Date

Printed Name

Relationship to Patient: Self Parent or Guardian