HUNTERDON
VISION THERAPY CENTER

Rachel M. Halatin, O.D.
1465 Route 31 South
Annandale, NJ 08801
Tel: (908) 323-2742
Fax: (908) 323-2737

Today's Date

First Name and Last name | Preferred Name | Date of Birth

Address | City | State | Zip

☐ Ok to text?

Home Phone | Cell Phone | Email Address

☐ Ok to e-mail?

Occupation (if student, grade in school) | Employer (if student, name of school)

Name of Insurer for ***MEDICAL*** care

Name of Primary Holder | Primary's Date of Birth | Primary's SSN#

Primary Care Physician | Office Location | Pharmacy Name | Pharmacy Location

## PAYMENT POLICY & RELEASE OF PATIENT INFORMATION

Payment is expected when services are rendered, unless other arrangements are made in advance. ***It is your responsibility to know your insurance coverage .*** Sensorimotor exams, Visual-Perceptual exams, vision therapy, and neuro-optometric rehabilitation therapy are all **self-pay** services. Pricing is as follows:

- ➔ Sensorimotor exam $350
- ➔ Visual-Perceptual exam $450
- ➔ Vision Therapy $185 per session (discounts will be applied for packages)
- ➔ Vision Therapy Progress Evaluation $175 per visit

I HAVE READ AND UNDERSTAND THE ABOVE

Signature of patient or responsible party | Date

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# VISION THERAPY QUESTIONNAIRE

Briefly state your main concerns and the main challenges you are having

Who first noted possible visual difficulties?

Who referred you to our office?

**MEDICATIONS/VITAMINS/SUPPLEMENTS**

**DRUG ALLERGIES AND OTHER SIGNIFICANT ALLERGIES**

**MEDICAL HISTORY**

Have there been any severe illnesses, injuries, hospitalizations, or physical impairments. If yes, please describe.

- ☐ Traumatic Brain Injury
  Date:
- ☐ Seizure Disorder
  Date of last seizure:
- ☐ Migraines or frequent headaches
- ☐ Learning Disabilities (ADHD, Autism, Dyslexia, etc)

Please list any other medical conditions you have been diagnosed with above.

Are you seeing a specialist or another provider such as a neurologist, psychologist, etc? If yes, state the reason and name of doctor/facility.

**FAMILY HISTORY**

Has anyone in your family ever been diagnosed or treated for:

- ☐ Strabismus (crossed eyes)
- ☐ Learning or reading problems
- ☐ Amblyopia (lazy eye)
- ☐ High nearsightedness, farsightedness, astigmatism
- ☐ Eye disease, please list
- Other:

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**SOCIAL HISTORY**

Do you enjoy interacting with peers?

What do you do for fun? (hobbies, interests, activities)

**ADDITIONAL INFORMATION**

Please let us know if there is anything we should know that would be helpful to be aware of?

*If you have the additional visual-perceptual or visual processing evaluation*, you will receive a written report of the examination.

We encourage you to share this information with your healthcare providers and school. Please list the names/addresses of the individuals you would like to receive this report:

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# HIPAA ACKNOWLEDGEMENT OF RECEIPT

This confirms that I read and was offered a copy of the Notice of Privacy Practices of Hunterdon Vision Therapy Center.

_____

Print name of patient

_____

Signature of patient or responsible party Date

List any individuals that have permission to be told about my eye care needs: (relative, spouse, child, etc.)

_____

_____

_____

_____

I give permission for the staff to leave a message on my answering machine or with whoever may answer my home phone.

Initial: _____

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# EDUCATION HISTORY

Has your child repeated any grades? If yes, which ones?

Is your child receiving any extra help in school or in any special classes? If yes, please describe.

Have there been any evaluations done by your child's school or by an outside provider/agency/specialist/ pediatrician? If yes, please bring a copy of the report or state the type and date of the evaluations and describe the results:

Psychological

Education

Speech/Language

Occupational therapy

Neurological

Medical

Other:

Does your child have IEP or a 504 plan? If yes, what is your child's classification and/or diagnosis?

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# DEVELOPMENTAL HISTORY

| *PLEASE ANSWER THE FOLLOWING:* | YES | NO |
|---|---|---|
| Were there any complications with pregnancy or during delivery? If yes, what complications? | ☐ | ☐ |
| Was your child born prematurely? If yes, how many weeks? | ☐ | ☐ |
| Did your child receive Early Intervention Services? If yes, what services? | ☐ | ☐ |
| Any concerns with speech now or in the past? | ☐ | ☐ |
| Any problems with fine motor coordination? (scissor cutting, proper pencil grip, tying shoes?) | ☐ | ☐ |
| Does your child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc? | ☐ | ☐ |

Child's birth weight _____

Is your child:
- ☐ Biological
- ☐ Adopted
- ☐ Foster
- ☐ Other

_____

At what age did your child begin crawling? _____

At what age did your child begin sitting unassisted? _____

At what age did your child begin walking unassisted? _____

At what age did your child begin to say two-three word phrases? _____

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**WHAT IS A BEHAVIORAL/NEURO-OPTOMETRIST –** a specialist in the field of optometry who assesses how your vision and visual system work together, allowing you to function comfortably in a school, work, athletic and spatial environment. Dr. Halatin does a 21-point exam designed to determine functional skills. She also checks visual acuity during this exam.

**WHAT IS A SENSORIMOTOR EXAM –** an assessment that covers all the aspects of a general eye examination, however looks much more closely at a number of different visual skills such as eye teaming, focusing, and visual motor skills. These skills are the building blocks for reaching full potential, particularly in the classroom. This exam is scheduled for 45 minutes. *This visit does not generate a report. Dr. Halatin may recommend a Visual Perceptual Evaluation.* Sensorimotor evaluations are self-pay **$350**.

**WHAT IS A VISUAL PERCEPTUAL EVALUATION –** this assessment investigates a number of different visual skills which are essential for learning, including visual form perception skills, directionality, visual motor integration, and visual auditory integration.
A nine-page report compiling the findings of both specialized examinations is included with the visual perceptual evaluation. Self-pay **$450**. Testing typically takes **1 ½ hours**. The report takes 3-4 weeks to complete.

**WHAT IS VISION/NEURO-OPTOMETRIC THERAPY –** an individualized treatment plan consisting of activities designed to remediate the deficits found during testing. The patient attends weekly 45-minute sessions. **Success is dependent upon the patient's motivation and the continuing support of the family, regular attendance at weekly therapy sessions, and the completion of home vision therapy assignments.** Reevaluation will take place every twelve sessions to determine what progress has been made.

There is no way to predict at the onset how long the therapy may last. The therapists need to assess the degree of dynamic (functional) skills and the motivation of the patient and family. Many factors, especially compliance with home support activities can affect the duration. Some patients may be done in 24 weeks, most 36 weeks, and cases like strabismus take at least a year.

Learning is multi-sensorial, and good visual skills are critical for success in the classroom, the playing fields, and workplace. *Vision therapy, however, does not teach reading, writing, or spelling.* It does not replace the support given by the family, speech, and language therapists, PTs or OTs. We cannot reverse certain diagnoses, like autism spectrum or severe nerve damage, but with patient compliance and individual effort, we often see improvements in visual-organization and an increased quality of life.

## SYMPTOMS OF BINOCULAR VISION DYSFUNCTION

Do any of the following apply to you or have been observed by others (family members, peers, etc.)? Please hand this checklist to the doctor at the ***beginning*** of your consultation.

| | FREQUENT | SOMETIMES |
|---|---|---|
| Skips lines while reading or copying | ☐ | ☐ |
| Loses place while reading or copying | ☐ | ☐ |
| Skips words while reading or copying | ☐ | ☐ |
| Substitutes words while reading or copying | ☐ | ☐ |
| Rereads words or lines | ☐ | ☐ |
| Reverses letters, numbers, or words | ☐ | ☐ |
| Uses a finger or marker to keep place while reading/writing | ☐ | ☐ |
| Reads very slowly | | |
| Poor reading comprehension | ☐ | ☐ |
| Difficulty remembering what has been read | ☐ | ☐ |
| Holds head too close when reading/writing (within 7-8 inches) | ☐ | ☐ |
| Squints, closes, or covers one eye while reading | ☐ | ☐ |
| Unusual posture/head tilt when reading/writing | ☐ | ☐ |
| Headaches following intense reading/computer work | ☐ | ☐ |
| Eyes hurt or feel tired after completing a visual task | ☐ | ☐ |
| Feels unusually tired after completing a visual task | ☐ | ☐ |
| Double vision | ☐ | ☐ |
| Vision blurs at distance when looks up from near work | ☐ | ☐ |
| Letters or lines “run together” or words “jump” when reading | ☐ | ☐ |
| Print seems to move or go in and out of focus when reading | ☐ | ☐ |
| Poor spelling skills | ☐ | ☐ |
| Writing is crooked or poorly spaced | ☐ | ☐ |
| Misaligned letter or numbers | ☐ | ☐ |
| Makes errors copying | ☐ | ☐ |

| | FREQUENT | SOMETIMES |
|---|---|---|
| Difficulty tracking moving objects | ☐ | ☐ |
| Unusual clumsiness, poor coordination | ☐ | ☐ |
| Difficulty with sports involving good eye-hand coordination | ☐ | ☐ |
| Eye turns in or out | ☐ | ☐ |
| Sees more clearly with one eye than the other | ☐ | ☐ |
| Feels sleepy while reading | ☐ | ☐ |
| Dislikes tasks requiring sustained concentration | ☐ | ☐ |
| Avoids near tasks such as reading | ☐ | ☐ |
| Confuses right and left directions | ☐ | ☐ |
| Becomes restless when working at his/her desk | ☐ | ☐ |
| Tends to lose awareness of surrounding when concentrating | ☐ | ☐ |
| Must “feels” things to see them | ☐ | ☐ |
| Car sickness | ☐ | ☐ |
| Unusual blinking | ☐ | ☐ |
| Unusual eye rubbing | ☐ | ☐ |
| Dry eyes | ☐ | ☐ |
| Watery eyes | ☐ | ☐ |
| Red eyes | ☐ | ☐ |
| Eyes bothered by light | ☐ | ☐ |
| Trouble copying from board to book | ☐ | ☐ |
| Responds better orally than in writing | ☐ | ☐ |
| Erases excessively | ☐ | ☐ |
| Reverses letters and numbers | ☐ | ☐ |
| Mistakes words with similar beginnings | ☐ | ☐ |