MOUNTAINVIEW
VISION THERAPY

3909 Creekside Loop, Suite 150, Yakima, WA Phone: (509) 972-6688 Fax: (509) 823-4433

Last Name: _____ First Name: _____ Middle Initial:_____ DOB: _____

Preferred Name:_____ Occupation: _____ M or F or Other

Address:_____ Home Phone: _____ ☐ Preferred

_____ Cell Phone: _____ ☐ Preferred

Email: _____ Other Phone: _____ ☐ Preferred

Emergency Contact:_____ Phone Number:_____ Relationship: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Eye Doctor: _____ Last Eye Exam Date:_____

Family Medical History

Mark each box Yes or No to indicate if any member of your family has had these diseases. Family history includes your parents, grandparents, and siblings.

		Relationship to Patient			Relationship to Patient
☐ **Y** ☐ **N**	Blindness		☐ **Y** ☐ **N**	High Blood Pressure	
☐ **Y** ☐ **N**	Cataract		☐ **Y** ☐ **N**	Heart Disease	
☐ **Y** ☐ **N**	Macular Degeneration		☐ **Y** ☐ **N**	Thyroid Disease	
☐ **Y** ☐ **N**	Glaucoma		☐ **Y** ☐ **N**	Diabetes	
☐ **Y** ☐ **N**	Retinal Detachment		☐ **Y** ☐ **N**	Cancer Type:	
☐ **Y** ☐ **N**	Strabismus (eye wanders)		☐ **Y** ☐ **N**	Lupus	
☐ **Y** ☐ **N**	Amblyopia (Lazy Eye, reduced vision even with glasses)		☐ **Y** ☐ **N**	Dyslexia or other reading problems	
			☐ **Y** ☐ **N**	Other:	

Personal Medical History

Indicate Yes or No for any of your current diagnoses or symptoms in each of the following. If yes, please describe:

☐ **Y** ☐ **N**	General Constitution (unexplained fever, weight loss or gain, etc.)	
☐ **Y** ☐ **N**	Eyes (Glaucoma, retinal detachment, macular degeneration, cataracts, etc.)	
☐ **Y** ☐ **N**	Ears, Nose, Throat, Mouth (hearing loss, chronic nasal congestion, chronic cough)	
☐ **Y** ☐ **N**	Respiratory (asthma, chronic bronchitis, shortness of breath, etc.)	
☐ **Y** ☐ **N**	Cardiovascular (diabetes, hypertension, heart problems, etc.)	
☐ **Y** ☐ **N**	Gastrointestinal (diarrhea, constipation, hernia, ulcers, etc.)	

Name: _____ DOB: _____ Date: _____

☐ **Y** ☐ **N**	Genitourinary (painful urination, frequent urination, jaundice, etc.)	
☐ **Y** ☐ **N**	Hematological/Lymphatic (anemia, bleeding problems, etc.)	
☐ **Y** ☐ **N**	Musculoskeletal (Muscle Pain, trauma, osteoarthritis, osteoporosis, etc.)	
☐ **Y** ☐ **N**	Skin (Eczema, Psoriasis, rashes etc.)	
☐ **Y** ☐ **N**	Neurological (Epilepsy, Cerebral Palsy, tumor, etc.)	
☐ **Y** ☐ **N**	Psychiatric (ADHD, Autism, Depression, anxiety, etc.)	
☐ **Y** ☐ **N**	Endocrine, Allergic, Immunological (Diabetes, Thyroid problem, Lupus, etc.) **Please list all allergies** (food, environment, medication)	
☐ **Y** ☐ **N**	Concussion, head injury, stroke, other neurological insult Date: _____ ***If yes, please also complete the Neurological Insult Intake Questionnaire***	
☐ **Y** ☐ **N**	Other – please specify	

Primary Care Provider Name:_____ Date of Last Exam:_____
Does your primary care doctor have any areas of concern regarding your health? _____

_____

Do you currently or have you in the past used tobacco products? ☐ **Yes, currently** ☐ **Yes, in the past** ☐ **No**
If yes, please describe the types of tobacco products and the amount of use. If you are no longer using them, include what year you quit using them. _____

_____

Do you consume alcohol? ☐ **Yes** ☐ **No** **If yes, how many drinks per week?** _____
If you use them, please describe your use of Recreational/Street drugs (How long you have taken them, what type, the amount taken, and the frequency of taking them)? ☐ **N/A** _____

_____

Please list all current medications:

1._____ 3. _____

2. _____ 4. _____

Female: Are you pregnant? ☐ **Y** ☐ **N** If yes, how many months pregnant are you?_____

Developmental History

Check Yes or No for each of the following areas: Please Explain Below

☐ **Y** ☐ **N**	Delays in **gross or fine** motor development (i.e. difficulties learning to ride a bike, catch a ball, play sports, tie shoes, draw/write etc.)? Has a delay been diagnosed? ☐ **Y** ☐ **N**	
☐ **Y** ☐ **N**	Delays in learning to crawl or walk? (please note if you skipped crawling) Has a delay been diagnosed? ☐ **Y** ☐ **N**	
☐ **Y** ☐ **N**	Other Developmental Delays Has a delay been diagnosed? ☐ **Y** ☐ **N**	

Name: _____ DOB: _____ Date: _____

☐ **Y** ☐ **N**	Dyslexia or other reading problems Has a delay been diagnosed? ☐ **Y** ☐ **N**	
☐ **Y** ☐ **N**	Attention difficulties, ADD, ADHD? Have you received a formal diagnosis? ☐ **Y** ☐ **N**	
☐ **Y** ☐ **N**	Born Premature or Complications at Delivery	
☐ **Y** ☐ **N**	Exposed to drugs in utero	
☐ **Y** ☐ **N**	Exposed to alcohol in utero	

Have you been evaluated by or received treatment from any of the following professionals? If so, please specify the provider and/or location.

Provider/Location	Service	Date	Findings, Recommendations, Treatment details
Neuropsychologist	☐ Evaluation ☐ Treatment		
Occupational Therapist	☐ Evaluation ☐ Treatment		
Speech/Hearing Therapist	☐ Evaluation ☐ Treatment		
Physical Therapist	☐ Evaluation ☐ Treatment		
Mental Health Care Professional	☐ Evaluation ☐ Treatment		

Have you been prescribed glasses? ☐**Y** ☐ **N** If yes, do you wear the glasses? ☐ **Y** ☐ **N** ☐ **Sometimes**
Date of most recent prescription: _____ At what age did you start wearing glasses? _____

Please estimate your reading ability: ☐Poor ☐Fair ☐Average ☐Above Average ☐Excellent
Hours per day spent on a computer: _____ Hours per day spent reading or studying: _____
Are you performing up to your potential? _____ If no, what do you feel is hindering your performance? _____

Strabismus/Amblyopia (Wandering/Crossed or Lazy Eyes) **Check all that apply**

Direction of wandering eye: ☐ Inward ☐ Outward ☐ Up ☐ Down Which Eye: ☐Right ☐Left ☐Both
At what age did you/others first notice the eye wander? _____ How often does your eye(s) wander? _____

Have you had surgery to correct the wandering eye? ☐Yes (please list) ☐No Number of surgeries: _____

Date: _____ Performed by: _____ ☐Right eye ☐Left eye ☐Both eyes

Date: _____ Performed by: _____ ☐Right eye ☐Left eye ☐Both eyes

Do you have reduced vision in one eye even with glasses? ☐No ☐ Right Eye ☐ Left Eye ☐ Both Eyes
Who first diagnosed you with Amblyopia (reduced vision with glasses)? _____ Age:_____

Have you been prescribed a patching regimen? ☐Yes, currently ☐Never ☐Yes, previously at age(s): _____

If yes, how many hours per day? _____ How many days per week? _____

Kind of patch used: ☐Black patch ☐Eye Drops ☐Other: _____

Who prescribed this patching regimen? _____ When was it prescribed? _____

Was/Is the regimen followed? ☐ Yes ☐ No ☐ Sometimes (please specify): _____

Name: _____ DOB: _____ Date: _____

Headaches **check all that apply**

Do you experience headaches when reading, working on a computer, or performing other visual tasks? ☐ Yes ☐ No

Location of headaches: ☐Forehead ☐Behind eyes ☐Temples ☐Above ears ☐Top ☐Back

☐More on the right side ☐More on the left side ☐Equally on both sides ☐Other_____

Frequency of headaches: _____ Duration: _____

Severity on 1 to 10 scale (10=most severe): _____

Medication(s) and/or relief strategies used (include how well each works to relieve headache): _____

_____

_____

Is there any other information you feel would be helpful or important in your treatment?_____

_____

_____

_____

_____

Convergence Insufficiency Symptom Survey	Never	Infrequently	Sometimes	Fairly Often	Always
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim or appear to float on the page?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a pulling feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to reread the same line of words when reading?					
Total (Please add up each of the columns)					
Multiply the **Total** by the following	**x0**	**x1**	**x2**	**x3**	**x4**
Subtotal					

Grand Total (Sum of Subtotals) _____ Date Scored: _____

Name: _____ DOB: _____ Date: _____

Visual Signs and Symptoms **check all that apply**

☐	Decreased reading speed	☐	Covers an eye when reading
☐	Decreased reading comprehension	☐	Accident prone
☐	Short attention span with reading	☐	Poor coordination and/or balance
☐	Avoids reading	☐	Dislikes sports/physical activities
☐	Poor performance at work or school	☐	Poor performance in sports/physical activities
☐	Evening reading/computer work is strenuous	☐	Poor rhythm and/or timing
☐	Takes longer than normal to read/do work	☐	Poor depth perception
☐	Difficulty focusing between near and far	☐	Often trips, falls, or bumps into things
☐	Difficulty reading words/signs at a distance	☐	Frequently drops utensils or knocks over drinks

10 Point Symptom Survey

On a scale from 0-10 (10 being the most severe), how severe are the following symptoms while doing visual tasks?

Symptom	Score	Comments
Headaches including frequency and severity		
Eye pain soreness, discomfort		
Eye fatigue and/or general fatigue		
Double vision shadowing of letters; words moving or floating on the page		
Blurry vision even though wearing glasses, or told glasses are unnecessary		
Loss of place while reading skipping words/lines, needing to reread		
Poor Motor Coordination and/or Difficulties with depth perception accident prone; trips, falls, runs into things; poor hand-eye coordination; avoids or has poor performance in sports; frequently knocks things over; poor rhythm and/or timing; poor handwriting		
Academic concerns low interest in reading/school work, poor grades, homework takes longer to complete than it should		
Visual Perceptual Difficulties letter, word, or number reversals; confuses similar words, letters, numbers, or symbols; gets lots in details; fatigues or becomes confused with too much info on a page; doesn't recognize the same word on a different page; poor visual recall		
Balance, Dizziness, Vertigo, Disorientation, Nausea, Motion Sickness		
Poor attention poor concentration, hyperactivity		
Brain fog, sensory overstimulation, motor overload Overwhelmed or unable to think clearly with too much stimulus (light, sound, busy visual environments/patterns); difficulty sitting still or exhibits reflexive movements due to overstimulation		
Emotional or Behavior problems poor self-esteem, poor confidence, easily frustrated, anxiety, depression, ADHD		
Eye Turn eye wanders outward or inward		
Other – Please specify		

Name: _____ DOB: _____ Date: _____

RELEASE OF INFORMATION:

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I, _____ give MOUNTAINVIEW VISION THERAPY, permission to release any Protected Health Care Information regarding my medical records, including diagnosis to other health care professionals, specifically, but not limited to those listed below, when it is necessary for the treatment of my visual condition.

_____ Primary Care Physician/Clinic

_____ Other Physician/Clinic

_____ Primary Eye Doctor/Clinic

_____ Spouse/Significant Other

Signatures:

_____ Patient Signature

_____ Date

Expires on: ☐ End of Treatment (OR)

☐ _____ Specific Date

****

Cash & Insurance Patients – ONLY AN ESTIMATE:

I understand that payment in full is due at time of service unless other arrangements have been made.

Mountainview Vision Therapy is willing to provide you with an ESTIMATE of what your insurance will or will not cover. However, we cannot and do not guarantee that the ESTIMATE we provide is correct. When we as the provider or you call in to get the ESTIMATE it is given with the statement "this is not a guarantee of payment". Please understand that while we will assist you in understanding your benefits, we have no influence over your coverage. You are ultimately responsible for all fees and charges on your account.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I also give permission Mountainview Vision Therapy to release any Medical Records requested by my insurance company for claim processing. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Thank you,

I have read and accept this policy,

Patient name (Printed): _____

Signature of Patient: _____ Date: _____

Name: _____ DOB: _____ Date: _____

Statement of Privacy Practices
Mountainview Vision Therapy

3909 Creekside Loop, Suite 150
Yakima, WA 98902
Phone: (509) 972-6688

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend your privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our vision and medical care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone that you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality vision and medical care, implement payment activities, conduct normal optometric practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history and health records. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for third party marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments, including voice mail messages, answering machines, postcards, and email.

Patient Rights
You have the right to request copies of your healthcare information and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

HIPAA Privacy Practice Acknowledgment:
I have received or was offered and declined a notice of privacy practices.

Patient Name (Printed): _____

Signature of Patient: _____ Date: _____