**DEVELOPMENTAL**
**& BEHAVIORAL**
**OPTOMETRISTS**

**PAULINE K. BUCK, OD, F.C.O.V.D., F.A.A.O**

WELCOME TO OUR OFFICE.

WE THANK YOU FOR CHOOSING US. DR. BUCK AND STAFF

Print Name (Last) _____ (First) _____

Address_____

City/State _____Zip Code _____

Home Phone (___) _____

Work Phone (___) _____

Cell Phone (___) _____

Social Sec. ____-____-_____

Email Address _____

Occupation _____ Employer_____

Date of Birth _____

Marital Status ____ If Child, Parent's Name_____

Name of Primary Care Physician/Pediatrician _____Phone_____

What is the reason for your visit?_____

Insurance Name:_____Insurance ID#:_____

Primary Holder:_____

How did you find out about our office?_____

If someone referred you please indicate name: _____.

May we use your name in thanking that person? Yes____ No _____

4770 Biscayne Blvd Suite #550 Miami, Florida 33137
Phone: (305) 576-5338 Fax: (305) 576-5366
www.drbuckvisiontherapy.com paulinekbuck@bellsouth.net

**Enabling success through visual development**

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Individually Identifiable Health Information Privacy Policy

Dr Buck's office has applied reasonable safeguards and implemented standards with respect to the primary use or disclosure of individually identifiable health information. We have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures of information not permitted by the privacy rule, as well as that limit incidental uses or disclosures.

For example, we have counseled our staff in such measures as:

- to speak quietly when discussing a patient's condition with family members in a waiting room or other public area;
- to avoid using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- to isolate or locking file cabinets or records rooms;
- to provide additional security, such as passwords, on computers maintaining personal information.

We also limit who has access to protected health information, and under what conditions, based on job responsibilities and the nature of the business.

Additionally, Dr Buck's office obtains satisfactory assurances from its business associates that the business associates will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity.

Dr Buck may share information with other covered entities for the purposes of providing treatment. Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.

Dr Buck may occasionally send information discussing new treatment options or products. We will not disclose individual health information in any of these marketing communications. Dr Buck has a policy of providing patients with a courtesy reminder of appointment times and/or order status either via telephone, printed or electronic communication. We will not release any products or information regarding a patient to another individual without verbal or written consent from said patient.

**Acknowledgment**

I have been notified of, and agree to, Dr Pauline Buck's conformance to the Standards for Privacy of Individually Identifiable Health Information.

_____

Print Name

_____

Signature Date

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# Neurodevelopmental patient history

*This questionnaire will allow us to plan for your appointment, and will give us much background information about you. Please fill in as fully as you are able.*

Name
Date of Birth

**This is your opportunity to tell us about all areas in which your vision is not serving you well.**

**What is your main reason for coming here today**?

**Are there times when your vision (or present lens) isn't quite right**?

**Are there any activities you would enjoy doing, but must restrict because of your vision**?

Date of your last eye examination  Have you ever had vision therapy? ❑ Yes ❑ No

Have you ever worn glasses? ❑Yes ❑No  Do you wear glasses now? ❑ Yes ❑No

*If yes:* ❑ for distance only ❑ for near only ❑ wear them full time
❑ for computer use ❑ sports

Do you wear contact lenses at this time? ❑Yes ❑No  What type?

Have you had problems wearing contacts? ❑Yes ❑No  Describe
Have you been told you cannot wear them? ❑Yes ❑No
Are you interested in trying contacts? ❑Yes ❑No

*Please describe in detail, including information on glasses, any orthoptic exercises, surgery, patching etc. that may have been used. If you have a copy of the current spectacle prescription, please bring it with you to the exam.*

Who may we thank for your referral to us?

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# *Medical History*

Are you currently under a physician's care? ❑No ❑ Yes

Dr.'s name?_____

Why are you under care? _____

Date of last physical _____

Are you regularly taking pills or medications? ❑ No ❑ Yes

Please specify _____

How is your general health? (circle one) Excellelent Good Fair Poor

Have you ever been hospitalized?
*What was the reason for the hospitalization?*

Have you suffered any injuries i.e. a fall?
Have you ever had a high fever?
Have you ever had an ear infection? Have there been any hearing problems?
Have you been vaccinated? When was the most recent vaccination?

Are you presently being treated for any condition?
*Please detail.*

What is the treatment for this condition?
Therapy?
Type
With whom?

Do you have any allergies? or food sensitivity?
*Please detail.*

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Do you have any behavioral/psychological problems? yes / no

*If so, please detail...*

Is there a family history of learning/behavioral problems?

**Please check the conditions that apply to you or that run in your family.**

Respiratory Disease ❑Self ❑ Family
Cancer ❑Self ❑ Family
Diabetes ❑Self ❑ Family
Drug sensitive ❑Self ❑ Family
Elevated cholesterol ❑Self ❑ Family
Heart problem ❑Self ❑ Family
High blood pressure ❑Self ❑ Family
Thyroid ❑ Self ❑ Family
Migraine or other headaches ❑ Self ❑ Family
Head trauma ❑Self
Lazy eye ❑ Self ❑ Family

Turned eye ❑ Self ❑ Family
Color "blind" ❑ Self ❑ Family
Light sensitive ❑ Self ❑ Family
Eyestrain ❑ Self ❑ Family
Dry eyes ❑ Self ❑ Family
Floaters/spots ❑ Self ❑ Family
Flashing lights ❑ Self ❑ Family
Retinal detachment ❑ Self ❑ Family
Blindness ❑ Self ❑ Family
Cataracts ❑ Self ❑ Family
Glaucoma ❑ Self ❑ Family
Eye surgery or injury
_____

## *A day in your life*

**OCCUPATION: What kind of work do you do?**

**What activities do you do at work:** ***(Circle all that apply )*** driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.
Other activities:_____

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**Do you use a computer on your job?** . . . . ❑ **Yes** ❑ **No** # of hours daily_____
What lenses do you wear? . . . . . ❑ **glasses** ❑ **bifocals** ❑ **contacts** ❑ None
Do letters ever seem to "swim"? . . . . . ❑ **Yes** ❑ **No**
Does office lighting bother you? . . . . . ❑ **Yes** ❑ **No**
Do reflections and glare bother you? . . . ❑ **Yes** ❑ **No**
Is it hard to proof-read, or find errors?. . . ❑ **Yes** ❑ **No**
When computing, do your eyes get . . . . ❑ **red** ❑ **dry** ❑ **ache**
Do you feel pain or discomfort in your. . . ❑ **neck** ❑ **shoulder** ❑ **back**
**Do you use a computer at home?** . . . . . ❑ **Yes** ❑ **No** # of hours daily_____

**Do you experience any of the following discomforts at work or at home?**

❑ Headaches? ❑ Letters blur as you read? ❑ Occasionally see double?

❑ Eyestrain? ❑ Eyes red or watery? ❑ Pulling sensation near eyes?

❑ Get sleepy? ❑ Lose your place often? ❑ Do you avoid certain tasks?

❑ Does it take more and more effort to see clearly as the day wears on?

❑ Do you avoid reading after work, but read on weekends? How long can you read?_____

❑ Do you "hunch" closer to your work as the day wears on?

❑ Do street signs ever seem blurred as you drive home from work?

❑ Is it ever difficult to bring print or objects to clear focus? When?

**RECREATION AND LEISURE:**

**In what recreational activities do you participate?** (*Circle* all that apply) read racquetball tennis golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities_____

Do you wear any special or protective eyewear for your sport? ❑ **Yes** ❑ **No**

Does your vision, or do your lenses, interfere with any activity? ❑ **Yes** ❑ **No**

**What are you doing to protect your eyes from ultraviolet exposure?**_____

**Do you currently wear glasses that have an anti-reflective coating?** ❑ **Yes** ❑ **No**

**Television: is viewing ever uncomfortable?** Please describe your discomfort:_____

_____

Do you recline while viewing? ❑ **Yes** ❑ **No** **D**o your lenses work for TV? ❑**Yes** ❑ **No**

**Do you often play video games?** ❑ **Yes** ❑ **No** # of hours daily_____

What are your special interests and hobbies?

Are you well coordinated?

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Can you:

Ride a bicycle?

What age did you learn to ride without training wheels?

Ride a skateboard?
Ride a scooter?
Ride a ripstick?
Play an instrument?

## *Scholastic history*

What school/grade level did you complete?
What subjects did you excell in?
What subjects gave you the most trouble?

Please rate the following according to frequency: For the school age questions respond based on your performance when you were in school
0 is never, 1 is rarely, 2 is sometimes, 3 is often, 4 is always.

## *Physical Complaints*

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Headaches when reading or doing desk work. | 0 | 1 | 2 | 3 | 4 |
| 2. | Carsickness. | 0 | 1 | 2 | 3 | 4 |
| 3. | Upset stomach during reading or computer work. | 0 | 1 | 2 | 3 | 4 |
| 4. | Exhausted after a day at work | 0 | 1 | 2 | 3 | 4 |
| 5. | Blurred vision even though a routine eye examination has been normal. | 0 | 1 | 2 | 3 | 4 |
| 6. | Eyestrain during reading or desk work. | 0 | 1 | 2 | 3 | 4 |
| 7. | When reading, see the print dance. | 0 | 1 | 2 | 3 | 4 |
| 8. | When reading, see the print run together. | 0 | 1 | 2 | 3 | 4 |
| 9. | Print appears too small. | 0 | 1 | 2 | 3 | 4 |
| 10. | See two of things when only one is there. | 0 | 1 | 2 | 3 | 4 |
| 11. | Cover an eye when trying to read. | 0 | 1 | 2 | 3 | 4 |
| 12. | Tilt and turn head to side to ignore one eye when reading, writing or watching TV. | 0 | 1 | 2 | 3 | 4 |
| 13. | Squint when looking from near to far or from far to near. | 0 | 1 | 2 | 3 | 4 |
| 14. | Rub eyes when reading. | 0 | 1 | 2 | 3 | 4 |
| 15. | Hold book too closely; face too close to desk surface. | 0 | 1 | 2 | 3 | 4 |
| 16. | Move closer and further away from book, as if to "focus" | 0 | 1 | 2 | 3 | 4 |
| 17. | One eye turns in or out. | 0 | 1 | 2 | 3 | 4 |
| 18. | You have already been diagnosed with a Lazy Eye (amblyopia). | 0 | 1 | 2 | 3 | 4 |
| 19. | You've had surgery for a crossed eye but still has problems with either work or coordination. | 0 | 1 | 2 | 3 | 4 |

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## *Learning-to-Read*

| | | | | | | |
|---|---|---|---|---|---|---|
| 20. | Very slow at sounding out words even when the "rules" are known; i.e., knows the letter sounds for "**c**," "**a**," and "**t**," but labors to sound out "**cat**." | 0 | 1 | 2 | 3 | 4 |
| 21. | Omit small words. | 0 | 1 | 2 | 3 | 4 |
| 22. | Repeat letters or syllables in a word. | 0 | 1 | 2 | 3 | 4 |
| 23. | Read the first letter or two of the word and guess at the rest. | 0 | 1 | 2 | 3 | 4 |
| 24. | Fail to recognize same word in the next line. | 0 | 1 | 2 | 3 | 4 |
| 25. | Can read a word that is isolated and large on a flash card, but can't recognize the same word when it's smaller or squeezed into a line of print. | 0 | 1 | 2 | 3 | 4 |
| 26. | Confuse likeness and minor differences, such as substituting "**what**" for "**that**." | 0 | 1 | 2 | 3 | 4 |
| 27. | Reverse letters or words, such as "**b**" for "**d**" or "**was**" for "**saw**." | 0 | 1 | 2 | 3 | 4 |
| 28. | Need to use a finger to maintain place when reading. | 0 | 1 | 2 | 3 | 4 |
| 29. | Get lost when trying to sound out words of more than one syllable. | 0 | 1 | 2 | 3 | 4 |
| 30. | Reading improves if you use a pickup stick or pen tip to point to the parts of the words for your child, reducing the need for accurate eye control. | 0 | 1 | 2 | 3 | 4 |

## *Reading-to-Learn*

| | | | | | | |
|---|---|---|---|---|---|---|
| 31. | Read well for a short time then begin to make careless errors. | 0 | 1 | 2 | 3 | 4 |
| 32. | Rapidly tire out and lose comprehension when reading. | 0 | 1 | 2 | 3 | 4 |
| 33. | Whisper to self while reading silently so the words can go in "through the ears." | 0 | 1 | 2 | 3 | 4 |
| 34. | You can sound out or recognize the words but comprehension is better when you use your **ears** to listen to someone reading than when you use your own **eyes** to read. | 0 | 1 | 2 | 3 | 4 |
| 35. | Avoid reading whenever possible. | 0 | 1 | 2 | 3 | 4 |
| 36. | Reading comprehension is not so good as your intelligence would predict. | 0 | 1 | 2 | 3 | 4 |
| 37. | Will not attempt books with smaller print. | 0 | 1 | 2 | 3 | 4 |
| 38. | Love to be read to, but will not read on your own. | 0 | 1 | 2 | 3 | 4 |
| 39. | Enjoy buying books, but never read them. | 0 | 1 | 2 | 3 | 4 |
| 40. | Take forever to finish a book, even when interested. | 0 | 1 | 2 | 3 | 4 |
| 41. | Count pages before considering a book. | 0 | 1 | 2 | 3 | 4 |
| 42. | You read well, but reading skills don't reflect your intelligence and potential. | 0 | 1 | 2 | 3 | 4 |

## *Getting It on Paper*

| | | | | | | |
|---|---|---|---|---|---|---|
| 43. | Make errors in copying from desk to paper. | 0 | 1 | 2 | 3 | 4 |
| 44. | Copying assignments takes forever. | 0 | 1 | 2 | 3 | 4 |
| 45. | Handwriting is off the lines, going "up and down hill." | 0 | 1 | 2 | 3 | 4 |
| 46. | When writing, words are poorly spaced. | 0 | 1 | 2 | 3 | 4 |
| 47. | struggle to get thoughts down on paper. | 0 | 1 | 2 | 3 | 4 |

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| | | | | | | |
|---|---|---|---|---|---|---|
| 48. | In math, digits or columns are misaligned. | 0 | 1 | 2 | 3 | 4 |
| 49. | Copy words backwards; for example, **was** for **saw**. | 0 | 1 | 2 | 3 | 4 |
| 50. | Confuse **B**s and **D**s. | 0 | 1 | 2 | 3 | 4 |
| 51. | In math, become confused if there are too many problems on the same page. | 0 | 1 | 2 | 3 | 4 |
| 52. | Can spell out loud but not when having to write the words. | 0 | 1 | 2 | 3 | 4 |
| 53. | Makes errors when copying from reference book to notebook. | 0 | 1 | 2 | 3 | 4 |
| 54. | Brain moves faster than hands. | 0 | 1 | 2 | 3 | 4 |
| 55. | Leave out letters or words when copying. | 0 | 1 | 2 | 3 | 4 |
| 56. | When writing, can't spell the same words that were known in the past. | 0 | 1 | 2 | 3 | 4 |
| 57. | Spell words like they sound rather than correctly. | 0 | 1 | 2 | 3 | 4 |

## *Coordination and Sports*

| | | | | | | |
|---|---|---|---|---|---|---|
| 58. | Run into things. | 0 | 1 | 2 | 3 | 4 |
| 59. | Stumble, trip or fall. | 0 | 1 | 2 | 3 | 4 |
| 60. | Clumsy. Poor balance. | 0 | 1 | 2 | 3 | 4 |
| 61. | Awkward when moving. | 0 | 1 | 2 | 3 | 4 |
| 62. | Have/had difficulty in learning to ride a bike. | 0 | 1 | 2 | 3 | 4 |
| 63. | Knock things over. | 0 | 1 | 2 | 3 | 4 |
| 64. | Can't keep eye on the ball. | 0 | 1 | 2 | 3 | 4 |
| 65. | Catch "by feel," trying to grab the ball after it bounces off chest. | 0 | 1 | 2 | 3 | 4 |
| 66. | Spend all time reading. Avoids exercise, especially ball sports. | 0 | 1 | 2 | 3 | 4 |
| 67. | Glasses are rapidly becoming stronger. | 0 | 1 | 2 | 3 | 4 |
| 68. | Can't hit a ball. | 0 | 1 | 2 | 3 | 4 |
| 69. | In tennis, can't return lobed balls. | 0 | 1 | 2 | 3 | 4 |
| 70. | In baseball or soft ball, misjudge and run underneath pop flies. | 0 | 1 | 2 | 3 | 4 |

## *Riding a bicycle or driving*

| | | | | | | |
|---|---|---|---|---|---|---|
| 71. | Have difficulty judging the position of others. | 0 | 1 | 2 | 3 | 4 |
| 72. | Follow too closely. | 0 | 1 | 2 | 3 | 4 |
| 73. | Slow to respond. | 0 | 1 | 2 | 3 | 4 |
| 74. | Poor at parallel parking. | 0 | 1 | 2 | 3 | 4 |
| 75. | Have to be overly cautious. | 0 | 1 | 2 | 3 | 4 |
| 76. | Become apprehensive if asked to drive at night. | 0 | 1 | 2 | 3 | 4 |

## *Attention*

| | | | | | | |
|---|---|---|---|---|---|---|
| 77. | Attention is much better when using ears to listen than when using eyes to read. | 0 | 1 | 2 | 3 | 4 |
| 78. | Attention is good for math (except for story problems) but poor for reading. | 0 | 1 | 2 | 3 | 4 |
| 79. | Extra work is very difficult in the evenings | 0 | 1 | 2 | 3 | 4 |
| 80. | During reading and extra work there comes a point after which it does no good to push any further. Your brain "shuts down." | 0 | 1 | 2 | 3 | 4 |
| 81. | The longer you use eyes for reading or writing, the greater | 0 | 1 | 2 | 3 | 4 |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | the frustration and fidgeting become. | | | | | |
| 82. | Assignments aren't completed at work and have to be brought home. | 0 | 1 | 2 | 3 | 4 |
| 83. | Yoiu can't "stay on task" when reading or writing. | 0 | 1 | 2 | 3 | 4 |
| 84. | Need to put his/her hands on everything Information from eyes alone isn't enough. | 0 | 1 | 2 | 3 | 4 |
| 85. | Have to work to sit in a chair, seem to be constantly readjusting balance. | 0 | 1 | 2 | 3 | 4 |
| 86. | Have the same reading struggles whether on or off medication. | 0 | 1 | 2 | 3 | 4 |
| 87. | Attention is fine for "hands on" mechanical type activities. | 0 | 1 | 2 | 3 | 4 |

## *Behavior, Self Esteem, Relationships*

| | | | | | | |
|---|---|---|---|---|---|---|
| 88. | You feel stupid. | 0 | 1 | 2 | 3 | 4 |
| 89. | Self-confidence is low and/or attitude is poor. | 0 | 1 | 2 | 3 | 4 |
| 90. | You are either worn out or angry when coming home from work. | 0 | 1 | 2 | 3 | 4 |
| 91. | Your poor eye contact makes others assume you aren't listening. | 0 | 1 | 2 | 3 | 4 |
| 92. | You feel unhappy or withdrawn. | 0 | 1 | 2 | 3 | 4 |
| 93. | Your have books rather than friends. | 0 | 1 | 2 | 3 | 4 |
| 94. | Ridiculed by others in work environment | 0 | 1 | 2 | 3 | 4 |
| 95. | Your frustration at work seems to trigger behavior problems. | 0 | 1 | 2 | 3 | 4 |
| 96. | Extra work leaves you frustrated and tired. | 0 | 1 | 2 | 3 | 4 |
| 97. | In sports, you are left sitting on the bench. You aren't asked to participate. | 0 | 1 | 2 | 3 | 4 |
| 98. | Your struggle with work affects the whole family. | 0 | 1 | 2 | 3 | 4 |
| 99. | You aren't working up to potential and the whole family feels the frustration. | 0 | 1 | 2 | 3 | 4 |

Thank you for taking the time to fill this out.
Email these forms to drbuck4770@hotmail.com or
Fax (305) 576 5366.
Once I have reviewed your responses I will have my assistant contact you to set up a time for us to speak before setting up your appointment.
I look forward to meeting you.

Dr. Buck