Behavioral Optometry • Vision Therapy and Rehabilitation
Samantha Slotnick, OD, FAAO, FCOVD
495 Central Park Ave • Suite 301, Scarsdale, NY 10583 • (914) 874-1177 • www.DrSlotnick.com

WELCOME to the office of Dr. Samantha Slotnick. All information will be kept confidential.

TODAY'S DATE_____

□ Ins card(s) copied front/back □ ABN signed?
□ Records Release filed? Y/N □ Referral Needed? Y/N

Patient Information

Last Name: _____First Name _____M.I._____ Nickname _____

Sex: M / F / X Birthdate: _____ AGE____ Grade _____ School _____
○ ○ ○

Address: _____ City _____ State _____ Zip_____

Home # ( ) _____ Cell# ( ) _____ Email _____

Patient referred by: _____

Parents (or guardians):
Mother Name_____Cell #: _____Work#: _____
□ Permission to txt appt confirm'n?

Address (if different) _____

E-mail Address_____Best Contact # □H /□W/ □Cell/ □E-mail

Mother's Employer/Address_____

Father Name_____Cell #: _____Work#: _____
□ Permission to txt appt confirm'n?

Address (if different) _____

E-mail Address_____Best Contact # □H /□W/ □Cell/ □E-mail

Father's Employer/Address_____

In case of emergency notify:
Name _____ Phone # ( ) _____ Relationship _____

Medical insurance Information

Insurance Company_____
Member or Primary Insured's I .D. #_____ Group number _____
Primary Insured's name: _____ DOB_____
Relationship to Patient: _____

I request that payment of authorized insurance be made to Dr. Samantha Slotnick for any services rendered. I authorize any holder of medical information about me, to release to HCF and its agents any information needed to determine these benefits payable for related services. I also understand there may be procedures that are not covered by my insurance and I am responsible for payment, including but not limited to refraction. I understand that payment in full is expected when services are rendered and materials dispensed.

SIGNATURE _____ Date _____

HIPAA privacy acknowledgement - I was given and read, and understand my privacy rights under the HIPAA laws.

Parent/Guardian Signature_____ Date_____

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CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment. Email: *Support@DrSlotnick.com* ***Fax:*** *(914) 885-1463.* ***THANK YOU.***

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office ? Yes ☐ No ☐
If yes whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____
Male ☐ Female ☐
Birth Date: _____ Age: _____years _____months
Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand Select below: SELECT: Has guidance been given in use of hand? Yes ☐ No ☐

Please list the names and birth dates of your family:

	NAME		
Father/Caretaker	_____	Birth Date	_____
Mother/Caretaker	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____
Sibling	_____	Birth Date	_____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? _____ Policy #: _____
Name of Insured: _____
Social Security Number: _____ Driver's License #: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Child's current state of health: _____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

_____

Immunizations child has received:

Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses, bad falls, high fevers, etc.:

Age Severe Mild Complications

_____

_____

_____

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

_____

Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? Results and recommendations: _____

_____

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
				Epilepsy or Seizures	☐	☐	_____
				Other	☐	☐	_____

If other, please explain: _____

_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
If yes, what types? _____
Is your child active? Yes ☐ No ☐
moderately? Yes ☐ No ☐
extremely? Yes ☐ No ☐

Are there periods of
very high energy? Yes ☐ No ☐
very low energy? Yes ☐ No ☐
Explain: _____

DEVELOPMENTAL HISTORY
Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development?
Yes ☐ No ☐.
If yes, why? _____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____
Did your child creep (on all fours)? Yes ☐ No ☐ At what age? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐

VISUAL HISTORY
Has your child's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____
History of eye surgery? _____
Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation

PRESENT SITUATION
Why do you feel your child needs a visual evaluation? _____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? _____

Does your child report any of the following?	Yes	No	If yes, when?
Headaches	☐	☐	
Blurred vision / focus goes in and out	☐	☐	
Double vision	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Words move around on the page	☐	☐	
Motion sickness / car sickness	☐	☐	
Dizziness	☐	☐	

List any other complaints your child makes concerning his/her vision: _____

_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING WHEN OBSERVING YOUR CHILD:

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye	☐	☐	
Difficulty seeing distant objects	☐	☐	
Head close to paper when reading or writing	☐	☐	
Avoids reading	☐	☐	
Prefers being read to	☐	☐	
Tilts head when reading	☐	☐	
Tilts head when writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letter or words	☐	☐	
Reverses letter or words	☐	☐	
Confuses right and left	☐	☐	
Skips, rereads or omits words	☐	☐	
Loses place while reading	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Tires easily	☐	☐	
Difficulty copying from chalkboard	☐	☐	

	Yes	No	If yes, when?
Difficulty recognizing same word on different page	☐	☐	_____
Poor word attack skills	☐	☐	_____
Difficulty with memory	☐	☐	_____
Remembers better what hears than sees	☐	☐	_____
Responds better orally than by writing	☐	☐	_____
Seems to know material, but does poorly on tests	☐	☐	_____
Dislikes / avoids near tasks	☐	☐	_____
Short attention span / loses interest	☐	☐	_____
Poor large motor coordination	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty with scissors / small hand tools	☐	☐	_____
Dislikes / avoids sports	☐	☐	_____
Difficulty catching / hitting a ball	☐	☐	_____

TELEVISION VIEWING/ LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____
_____

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____
_____
Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____
Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐
What? _____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____
_____

Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance?
Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

GENERAL BEHAVIOR
Are there any behavior problems at school? Yes ☐ No ☐
If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? sag ☐ irritable ☐ other ☐
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still for long periods? Yes ☐ No ☐

FAMILY AND HOME
Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____
Does your child spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____
Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: _____
Does your child seem to have adjusted? Yes ☐ No ☐
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: _____
How does your child get along with:
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____
Did father or anyone in father's family have a learning problem? Yes ☐ No ☐
If yes, who? _____
Did mother or anyone in mother's family have a learning problem? Yes ☐ No ☐
If yes, who? _____

Do any, or did any, of the other children in the family have learning problems? Yes ☐ No ☐

If yes, who? _____

To what extent? _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

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 Dr. Samantha Slotnick when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Slotnick 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.

X _____ _____
Signature Date

_____
RELATIONSHIP TO PATIENT

I hereby give my permission to Dr. Samantha Slotnick to treat _____.
(Child's Name)

X _____ _____
Parent's or Guardian's Signature Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions on concerns that we may answer prior to your appointment, please do not hesitate to contact us.
You may leave a message for us 24 hours a day /7 days a week.

CANCELLATION POLICY:
Your extended appointment time with the doctor is reserved expressly for you & your child. There is a $50 Cancellation Fee for all appointments cancelled/rescheduled within 48 hours of the appointed time. If you need to modify, cancel or reschedule your appointment, please be sure to make your request via email no less than 48 hours in advance: Support@DrSlotnick.com

Please INITIAL HERE to acknowledge consent: X_____

Please arrive *15 minutes early* for your first examination to finish office registration, so that we will have the maximum opportunity to evaluate your child's visual status. THANK YOU.

SINCERELY,

SAMANTHA SLOTNICK, O.D., F.A.A.O., F.C.O.V.D.
CLINICAL DIRECTOR

Samantha Slotnick, OD, FAAO, FCOVD
495 Central Park Ave ● Suite 301
Scarsdale, NY 10583

Quality of Life Questionnaire

Name:_____ Date:_____

	PARENT OBSERVATIONS	Never	Seldom	Occasionally	Frequently	Always
1	I have blurred vision when looking at near objects.	0	1	2	3	4
2	I have double vision. (Seeing two objects rather than one.)	0	1	2	3	4
3	I have headaches with near work.	0	1	2	3	4
4	Words run together when I read.	0	1	2	3	4
5	My eyes burn, itch and water.	0	1	2	3	4
6	I fall asleep when I read.	0	1	2	3	4
7	I see worse at the end of the day.	0	1	2	3	4
8	I skip or repeat lines when reading.	0	1	2	3	4
9	I feel dizzy or sick to my stomach with near work.	0	1	2	3	4
10	I tilt my head or cover an eye when reading.	0	1	2	3	4
11	I have difficulty copying from the chalkboard.	0	1	2	3	4
12	I avoid reading and near work.	0	1	2	3	4
13	I leave out small words when reading.	0	1	2	3	4
14	I write uphill or downhill (My handwriting tends to slant up or down).	0	1	2	3	4
15	Columns of numbers appear misaligned.	0	1	2	3	4
16	I don't understand what I read.	0	1	2	3	4
17	I am poor in sports.	0	1	2	3	4
18	I hold my reading very close.	0	1	2	3	4
19	I have trouble keeping attention on reading.	0	1	2	3	4
20	I have difficulty completing assignments on time.	0	1	2	3	4
21	I often say, "I can't" before trying.	0	1	2	3	4
22	I avoid sports and games.	0	1	2	3	4
23	I have poor hand/eye coordination	0	1	2	3	4
24	I do not judge distance accurately.	0	1	2	3	4
25	I am clumsy.	0	1	2	3	4
26	I do not use my time well.	0	1	2	3	4
27	I do not do well in figuring out change (money).	0	1	2	3	4
28	I lose papers and belongings.	0	1	2	3	4
29	I have trouble with car/motion sickness.	0	1	2	3	4
30	I am forgetful with a poor memory.	0	1	2	3	4
	Totals:					
	20-24 points = suspect 25 points or more=refer for care Score:					

Samantha Slotnick, OD, FAAO, FCOVD
495 Central Park Ave ● Suite 301
Scarsdale, NY 10583

Quality of Life Questionnaire

Name:_____ Date:_____

	CHILD'S OWN PERSPECTIVE	Never	Seldom	Occasionally	Frequently	Always
1	I have blurred vision when looking at near objects.	0	1	2	3	4
2	I have double vision. (Seeing two objects rather than one.)	0	1	2	3	4
3	I have headaches with near work.	0	1	2	3	4
4	Words run together when I read.	0	1	2	3	4
5	My eyes burn, itch and water.	0	1	2	3	4
6	I fall asleep when I read.	0	1	2	3	4
7	I see worse at the end of the day.	0	1	2	3	4
8	I skip or repeat lines when reading.	0	1	2	3	4
9	I feel dizzy or sick to my stomach with near work.	0	1	2	3	4
10	I tilt my head or cover an eye when reading.	0	1	2	3	4
11	I have difficulty copying from the chalkboard.	0	1	2	3	4
12	I avoid reading and near work.	0	1	2	3	4
13	I leave out small words when reading.	0	1	2	3	4
14	I write uphill or downhill (My handwriting tends to slant up or down).	0	1	2	3	4
15	Columns of numbers appear misaligned.	0	1	2	3	4
16	I don't understand what I read.	0	1	2	3	4
17	I am poor in sports.	0	1	2	3	4
18	I hold my reading very close.	0	1	2	3	4
19	I have trouble keeping attention on reading.	0	1	2	3	4
20	I have difficulty completing assignments on time.	0	1	2	3	4
21	I often say, "I can't" before trying.	0	1	2	3	4
22	I avoid sports and games.	0	1	2	3	4
23	I have poor hand/eye coordination	0	1	2	3	4
24	I do not judge distance accurately.	0	1	2	3	4
25	I am clumsy.	0	1	2	3	4
26	I do not use my time well.	0	1	2	3	4
27	I do not do well in figuring out change (money).	0	1	2	3	4
28	I lose papers and belongings.	0	1	2	3	4
29	I have trouble with car/motion sickness.	0	1	2	3	4
30	I am forgetful with a poor memory.	0	1	2	3	4
	Totals:					
	20-24 points = suspect 25 points or more=refer for care Score:					

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Reservation Policy

It is an honor for our entire team to create personal relationships with our patients and their families. These relationships come from the ability to provide time for meaningful interactions with patients and caregivers, and sufficient appointment time for a comprehensive, whole-person approach to care.

All appointments are reserved.

A $45 reservation deposit will be applied towards your appointment, in full.

- Our scheduling software enables us to create tentative appointments with a 24-hour hold. These appointments may be **secured by reservation**.
  Tentative appointments are subject to removal, notified by email.
- We ask that as a courtesy, you notify us AS SOON AS POSSIBLE if you are unable to keep your appointment.
- While we do understand extenuating circumstances, **your Reservation Deposit will be forfeited if your appointment is cancelled OR rescheduled within 2 full business days of your appointment.**
  - Please note, *if you need to reschedule a* ***Tuesday*** appointment, please contact us by **Friday** to avoid forfeiting your reservation.
  - We offer to *return* any forfeited reservation deposit as a *credit on your account* when you keep *the next three* appointments without need of rescheduling.
- "Standing appointments" for Vision Therapy are already reserved, and managed with a separate policy.

Acknowledged: X_____, _____ _____

Sign Print Date

We are grateful for the opportunity to provide our patients and their families with time, care and support.

Sincerely,

Dr. Samantha Slotnick and Vision Team