Dr. Catherine A. Kennedy, OD, FCOVD
Developmental and Behavioral Optometrist
83 Cambridge Street, suite 1D
Burlington, Ma 01803
781-272-2187 fax 781-229-0869

WELCOME TO OUR OFFICE

We look forward to meeting you.

Doctor Kennedy is looking forward to providing your child with high quality personalized care. Your appointment time is reserved specifically for you. We do not overbook in anticipation of a cancellation or no-show. The doctor's emphasis is to maximize success for your child.

PLEASE FILL OUT THE PATIENT INFORMATION and HISTORY FORMS. You may email or fax it to us prior to your appointment or bring it with you. Copies of previous evaluations and reports may be faxed or brought with you.

Please bring any eyeglasses and/or contact lenses (and the contact lens prescription) with you.

PAYMENT POLICY

In order to provide this high quality personalized service, we are not affiliated with any insurance plan and provide service on a private pay basis only. Payment of the evaluation fee will be expected in full at the time of service. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt to submit to your insurance company.

REASON FOR VISIT: check all that apply

___school related vision problem
___eye teaming problem (turned eye lazy eye)
___myopia control/reduction
___sports vision enhancement
___vision problems after brain injury
___well baby vision check
___interest in Optometric Vision Therapy

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SPECIALIZING IN LEARNING RELATED VISION PROBLEMS and BINOCULAR VISION PROBLEMS

Please provide the following information as completely as possible. Use the back side of page if needed.

Child's Name(first, middle, last):_____

Prefers to be called:_____

ADDRESS:_____
street town zip

Name of School:_____ Grade:_____Date of Birth:_____

Parent's name:_____occupation:_____
Address(if different)
Email Address:_____

2nd Parent's name:_____occupation:_____
Address (if different)

Referred By:_____ or How Did You Hear About Dr. Kennedy?

Do you need a written report?_____(will be emailed to you)

Present Situation:

1. In what way does your child seem to have visual difficulty?

2. How does your child complain about his-her vision?

3. Does your child ever report any of the following and if so, when?

   a. Headache: yes – no when?_____
   b. Blur at far seeing: yes - no Blur at near: yes - no
   c. Double vision: yes -no when?_____
   d. Eyes "hurt or tired": yes -no when?_____

4. Do you see your child do any of the following? Circle each seen.

   close one eye, tilt or turn head when looking,avoid looking at books, avoid fine motor acivities

5. Does one eye seems to drift? What direction? How often?

Developmental history: (if for any reason this information is unknown please write NK)
I. Full term pregnancy?_____ Normal Birth?_____Any complications before, during or immediately following delivery? _____
2. Did your child crawl?_____ All fours_____ Age_____
3. At what age did child walk?_____
4. Age at first words? _____
5. Was child active? _____
6. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc:
_____
7. List illnesses (especially high fevers)
_____
8.Is your child currently receiving medical care /physical therapy/occupational therapy/speech-auditory therapy/complementary(alternative) therapy for any conditions? Please list the treatment and the diagnosis. Also include any medications or remedies. If there has been previous treatment or school-based care please note that also.

_____

_____

_____
9.Is there any history of head injury, falls, accidents or serious wounds in the head/neck/back area? If so please describe.

10.Does your child have allergies? yes___ no___

Visual History
1. How long has visual difficulty been noticed?_____
2. Has there been previous visual care?_____ If so, please detail below:

Doctor's Name	Approximate Date	Result (s)

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3. Please list family members who have any visual conditions, learning problems or similar medical conditions.
Name and Relationship Age (now) Visual,learning or medical condition and age it began (if known)

Is there any other information that would be helpful/important in our evaluation or treatment of your child?

Please note, Dr. Kennedy is not affiliated with any insurance plan and provides service on a private pay basis only. Payment is expected in full at the time of service. Check, cash, or credit card accepted. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt you may submit with your insurance claim.

Signature:_____ Date:_____