WELCOME TO FAMILY VISION CARE AND VISION THERAPY

A THOROUGH HISTORY HELPS US TO BEST ADMINISTER TESTS & RECOMMEND TREATMENT TO MEET THE VISUAL NEEDS OF YOUR SCHOOL-AGED CHILD.

PLEASE PRINT, FILL OUT AND BRING THIS FORM TO YOUR CHILD'S APPOINTMENT

Child's Name ________________________ Nickname____________ Exam Date ____________
Date of Birth _________ Age ___ Sex: M / F Pediatrician ______________ph.# __________
Name of School ___________________ Teacher ________________ Grade ________
Home Address ___________________________ City ________________Zip Code __________

Father's Name __________________________ Social Security # ________________________
Address ____________________________ City ______________ Zip Code ___________
Employer __________________ Occupation_________________ Email ________________
Home phone ______________ Cell phone______________ Work phone _______________

Mother's Name __________________________ Social Security # ________________________
Address ____________________________ City ______________ Zip Code ___________
Employer __________________ Occupation_________________ Email ________________
Home phone ______________ Cell phone______________ Work phone _______________

Person Responsible for this Account: Father ___ Mother ___ Other ________________________
Who does this Child live with? ____
Siblings and Ages ________________________ ________________________
________________________ ________________________

Vision Insurance: Vision Service Plan (VSP) Y / N Other ____________

Primary Medical Insurance	Member's Name	Secondary Insurance	Member's Name
____________________	______________	________________	______________

Who may we thank for referring you to our office? ______________________________

Names and addresses of individual or agencies you wish to receive results of our evaluation:

1. ____
2. ____
3. ____

WHAT IS THE MAJOR REASON FOR THIS VISUAL EVALUATION:

____ Periodic check-up ____ School Referral ____ Doctor Referral
____ Visual Symptoms ____ Learning Problem ____ Other____________

PLEASE STATE YOUR MAIN CONCERNS: ___________________________________
____

Date of last eye exam __________ with whom ______________________

Have the following vision treatments ever been prescribed or recommended? If yes, at what age?

Glasses ___________ Patching __________ Surgery ___________

VISUAL HISTORY	Yes	No	Unknown
1. Headaches……………………………………………………..	_______	_______	________
2. Blurred distance vision………………………………………	_______	_______	________
3. Blurred near vision…………………………………………..	_______	_______	________
4. Hold books closer than normal……………………………..	_______	_______	________
5. Eyes hurt or tire……………………………………………....	_______	_______	________
6. Eyes frequently red………………………………………….	_______	_______	________
7. Double vision or closes one eye………….………………..	_______	_______	________
8. Eye turn (crossed or wall-eyed)……………………………	_______	_______	________
9. Rubs or blinks excessively………………………………….	_______	_______	________
10. Makes errors when copying……………………………...	_______	_______	________
11. Loses place while reading…………………………………..	_______	_______	________
12. Poor reading comprehension……………………………….	_______	_______	________
13. Suffers from carsickness……………………………………	_______	_______	________
14. Have previous visual problems been diagnosed?	_______	_______	________

PLEASE COMPLETE OTHER SIDE.

ACADEMIC HISTORY

	Yes	No
1. Are you dissatisfied with child's school performance?.……...	_______	_______
2. Do teachers have concerns about school performance?…….	_______	_______
3. Has a grade level been repeated?…………………………...	_______	_______

4. Rate progress in the following subjects:

1 - below average *2 - average* *3 - advanced*

Reading ___ Spelling ___ Penmanship ____ Math ____ Writing ____ Phys. Ed ____

BEHAVIORAL HISTORY: Place a number in the blank to the left of the item that describes the child.

1 - Frequently **2 - Occasionally** **3 - Rarely**

___ Hyperactive
___ Easily distracted
___ Short attention span
___ Easily frustrated
___ Impulsive
___ Easily fatigued
___ Day dreams
___ Confuses right & left
___ Awkward or clumsy
___ Rejects eye-hand activities
___ Poor ability to organize work
___ Indistinct speech
___ Trouble with verbal instructions
___ Poor peer group relations
___ Behavior problems
___ Emotional problems
___ Does little voluntary reading
___ Reverses letters when reading or writing
___ Confuses letters or words when reading
___ Variable school performance (hour-to-hour, day-to-day)

DEVELOPMENTAL AND MEDICAL HISTORY:

At what age, in months, did the child: Crawl____ Walk alone____ Speak words clearly ____

Which describes the child's physical maturity for age (circle)?………………..Immature Average Advanced

If the answer is yes to any of the following, please explain in the space provided:

Any history of birth complications?……………………………...……………………………...……. Yes___No___

____

Any severe childhood illness, high fever, ear infections, injury, or physical impairment?………..…. Yes___No___

____

Any allergies? ………………………………………………………………………………………… Yes___No___

____

Are herbal, over-the-counter, or prescribed medications taken? …………………………………….. Yes___No___

List and state their purpose:____

Has hearing, auditory processing, or speech deficiency been diagnosed? ………………………… Yes___No___

____

Any unusual sensitivities to clothing, crowded places, tastes, loud sounds, or odors?…………....Yes___No___

____

Any previous testing, therapy or remedial assistance?……………………………………….…….Yes___No___

Type	Dates	By Who	Results
________________	____________	______________	_______________
________________	____________	______________	_______________
________________	____________	______________	_______________

Any family history and if so, whom? Glaucoma_________________ Cataracts______________________

High Blood Pressure_______________ Diabetes_________________ Color Deficiency_________________

Lazy Eye or Eye Turn______________ Blindness due to ____________Learning Difference_______________

Please note any other information that you wish to share:

Signature_______________________ Relation to child_______________ Date___________

Wtochild2/06

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