Children's Vision - Optometric Vision Therapy
Learning Related Vision Problems
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FAMILY EYE CARE

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To the parents of _____

Please complete this questionnaire and return it to our office prior to your child's appointment. We would appreciate your presence during the evaluation.

DEVELOPMENTAL HISTORY FORM

Whom may we thank for referring you to our office?_____

Nickname_____ Age_____ Sex: **M** **F**

Child's full name_____ Date of Birth_____

Address _____

Name of school that child attends_____

Address _____

Grade in school_____ Teacher's name _____

Mother's name_____

Address _____

Occupation_____ Place of work_____

Work number_____ Home number_____

Social Security number_____ Cell number _____

e-mail_____

Father's name_____

Address _____

Occupation_____ Place of work_____

Work number_____ Home number_____

Social Security number_____ Cell number _____

e-mail_____

Who is the financially responsible party? _____

If there is an insurance claim, please bring the necessary information.
It is required that fees be paid at the same time that services are provided.

HEALTH HISTORY

Were there any pregnancy or birth complications? If so, please describe.

_____

_____

_____

APGAR scores_____ Birth Weight_____

Has your child had any serious injuries or surgery? If so, please describe.

_____

_____

_____

Is your child adopted?_____ Who is their physician?_____

Is there a family history of glaucoma, diabetes, lazy eye, or other serious visual problems? If so, what are the problems and what are the family relationships?

_____

_____

_____

Is there a family history of color blindness?_____

Is your child currently taking over the counter or prescription medication? _____

If so, what? _____

_____

_____

Does your child have allergies? If so, to what, and how is it treated?

_____

_____

Do they get adequate rest?_____

Has there been a history of ear infections?

_____

Does your child get car sick? _____

VISUAL HISTORY

Has there been any prior visual care?_____ Doctor's Name _____

When?_____

Were glasses prescribed?_____

When were they to be worn? _____

Has your child worn them without constant reminding? _____

If your child has had glasses prescribed, please bring them with you.

Why do you you think your child needs a visual examination?

_____

_____

Was attention recommended by the teacher or school nurse? If so, why?

_____

_____

Do your child's eyes ever appear red, watery, or tired? _____

_____

Have your child's eyes ever appeared to turn from proper alignment? _____

_____

DOES YOUR CHILD:

Squint? _____

Rub their eyes? _____

Get close to their reading or writing? _____

Move in or out to focus? _____

Close or cover one eye? _____

Turn their head to read or write? _____

Turn their head to concentrate on detail? _____

Blink frequently? _____

Seem unusually sensitive to light? _____

DOES YOUR CHILD REPORT:

Headaches? _____

Blurring at far? _____

Blurring at near either when they start to read or after reading awhile? _____

That the words appear to change or move? _____

Double Vision? _____

Dizziness? _____

DEVELOPMENTAL HISTORY

Has your child met their developmental milestones as expected? (rolling over, sitting up, creeping, crawling, standing, walking) _____

Do you feel that they are coordinated for their age? _____

Does your child have speech difficulty for their age? _____

Have they received speech therapy, OT, PT, or any other kind of therapy? _____

_____

Has their attention been captured by looking at books, playing with cars, dolls, blocks, puzzles, drawing, watching television, listening to music? _____

When did they master letters? _____

How do they get along with their peers? _____

Do they have difficulty following directions? _____

Do they frequently misplace objects? _____

Do they participate in ball sports? If so, which ones and how do they do? _____

_____

ACADEMIC HISTORY

Does your child like to read? _____
How long can your child read? Minutes_____ Hours_____
Does your child enjoy being read to?_____
Do they seem to understand and remember the story?_____
Has your child had difficulty reading or learning to read? _____

_____
Do they have difficulty spelling?_____
Do they lose their place, make frequent errors, leave out or make errors on small words, or farther along in their reading, not recognize a word they just learned?

_____

_____
Does your child have to use a marker to keep their place while reading?_____
Do they turn their head while reading? _____
Do they have trouble with reading comprehension? _____
As reading time increases, does the quality or reading or comprehension change? _____
If so, please describe: _____
How is their handwriting?_____
Do they have difficulty completing reading or desk work on time? _____

_____
Does their work get sloppier as it progresses? _____
Are there more errors? _____
Do they avoid reading or writing? _____
Does your child have difficulty copying? If so, please explain: _____

_____
Do they have difficulty understanding mathematics?_____
Do they use a computer or other electronic devices?_____
If so, for how long and does it seem to cause visual discomfort?_____
Is your child performing up to expectations in school? _____
Has your child ever repeated a grade? If so, which one? _____

I hereby give permission to **Family Eye Care** for the release of confidential and other information on

(child's name) _____ to _____
(Name of school, institution, professional)
to _____
(Name of school, institution, professional)
to _____
(Name of school, institution, professional)

Signed_____ to _____
(Parent or Guardian) (Name of school, institution, professional)

Date_____ to _____
(Name of school, institution, professional)

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO RECEIVE CARE AND ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER PRIOR ARRANGEMENTS ARE MADE. I AUTHORIZE THE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

PATIENT/GUARANTOR SIGNATURE DATE