Child/Student History

Reason for visit:(check all that apply)

[ ]First Exam [ ]Routine Exam [ ]Doctor Recommendation [ ]Change or update prescription
[ ]School/Teacher Recommendation [ ]Educational Referral [ ]Occupation/Physical Therapy Referral
[ ]Underachieving in school [ ]Underachieving in sports [ ]Developmental Delays [ ]Traumatic Head Injury
[ ]Other _____

List specific issues you would like addressed today:

_____

Have you ever noticed any of the following in your child:

[ ]Fatigue with sustained near work	[ ]Holds reading close	[ ]Holds reading far away
[ ]Reading below age level	[ ]Squinting	[ ]Excessive tearing
[ ]Poor reading comprehension	[ ]Poor spelling	[ ]Excessive blinking
[ ]Performing below potential	[ ]Avoidance of near work	[ ]Excessive eye rubbing
[ ]Distorted posture while reading	[ ]Falls asleep reading	[ ]Poor penmanship
[ ]Loses place often while reading	[ ]Letter reversals	[ ]Confuses right & left
[ ]Needs finger to keep place	[ ]Shutting or covering one eye	[ ]Poor attention span
[ ]Skips words/sentences when reading/copying	[ ]Eye turns in or wanders out	[ ]Can't sit still
[ ]Poor general coordination	[ ]Bumps into objects	[ ]Avoids team sports
[ ]Sizing/spacing/copying difficulties	[ ]Unusual pencil grip	[ ]Eyes frequently red
[ ]Doesn't recognize same word in next sentence	[ ]Frequent styes	[ ]Encrusted eyelids

Comments:_____
_____

Visual History:

Does your child, or has your child ever worn glasses? [ ]Yes [ ]No If so, were the glasses [ ]full time [ ]near only [ ]far only
Contact lenses? If so, type: _____ Disinfecting system being used: _____
Has your child ever had (check all that apply and provide details)?:

[ ]Eye disease _____ [ ]Eye surgery _____
[ ]Eye injury _____ [ ]Lazy Eye_____
[ ]Color blindness _____ [ ]Other _____

Developmental History:

Was pregnancy full term? [ ]Yes [ ]No Were pregnancy and birth normal? [ ]Yes [ ]No
Please list any complications:_____
Please list age at which your child first did the following: Crawled _____Walked _____ Talked _____
Which hand does your child prefer to use? [ ]Left [ ]Right
Was handedness ever changed? If so, please explain:

_____

Nutritional Information:

How would you rate your child's appetite? [ ]Excellent [ ]Very good [ ]Good [ ]Fair [ ]Poor
Does your child seem overly sensitive to: [ ]Sugar [ ]Preservatives
Nutritional Philosophy: _____

School History:

Age at time of entrance _____ Have any grades been repeated? [ ]Yes [ ]No If so, which one? _____
Does your child like school? [ ]Yes [ ]No Is school work: [ ]Better than average [ ]Average [ ]Below average
Have there been any school difficulties? [ ]Yes [ ]No Please explain: _____

_____

What subjects does your child consider easiest? _____ Hardest? _____
What are your child's favorite activities? _____
How many hours of TV does your child watch each day? _____ Daily time spent playing video/computer games? _____
Does your child have any special talents or interests (are, music, sports, etc.)? _____