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PATIENT INFORMATION

Patient Name: ____

Date of Birth: ______________ Sex at Birth: Male Female

Phone Number: ( ) ___________ - ____________

Home Address: ____

RESPONSIBLE PERSON(S) INFORMATION

Name: ____

Relationship to Patient: ____________________

Phone Number: ( ) ___________ - ____________

Home Address: ____

Same contact information as the patient:

Name: ____

Relationship to Patient: ____________________

Phone Number: ( ) ___________ - ____________

Home Address: ____

Same contact information as the patient:

PATIENT HISTORY

Were you referred to our office? Yes No

If yes, by whom? ____

Chief Complaint / Reason for Visit:

____

When did you notice the problem? ____

Has the problem become: Better Worse Stayed the Same

Has there been any previous treatment? Yes No

If yes, please describe:

____

SCHOOL HISTORY

Is your child homeschooled? Yes No

What grade is your child in? ____________________

Has your child repeated a grade? Yes No

If yes, which grade: ___________________

Does your child like their teacher? Yes No

Is your child schoolwork: Above Average Average Below Average

Which classes are at or **ABOVE** grade level?

Language Arts Math Music PE Science Social Studies

Which classes are **BELOW** grade level?

Language Arts Math Music PE Science Social Studies

Does your child enjoy reading? Yes No

Does your child prefer to be read to rather than reading on their own? Yes No

Do you feel that your child is reaching their full potential? Yes No

Does your child attend any special classes? Yes No

If yes, please describe: ____

Does your child have an IEP or 504? Yes No

If yes, what accommodations are in place?

____

Has your child been diagnosed with: Dyslexia ADD/ADHD Behavioral Issues

ADDITIONAL TESTING HISTORY – Please select all that apply and summarize the results.

Educational	Hearing	Neurological	Psychological
Speech Therapy	Occupational Therapy	Physical Therapy	Chiropractor

____

____

____

PATIENT MEDICAL HISTORY

Primary Care Doctor: ____

Last Visit Date: ______________________ Reason for Visit: ____________________________

Has your child been diagnosed with or treated for the following health problems?
If yes, please describe:

Cancer: ____

Digestive / Gastrointestinal: ____

Ear / Nose / Throat: ____

Genitourinary: ____

Neuro / Traumatic Brain Injury: ____

Muscle / Bone / Arthritis: ____

Psych / Behavioral: ____

Skin Condition / Disorders: ____

High Blood Pressure / Cholesterol: ____

Diabetes / Thyroid / Endocrine: ____

Respiratory / Asthma: ____

Immune / Allergies: ____

Is your child taking any medications? Yes No

If yes, which medications and what dosage?

____

Does your child have any known allergies? Yes No

If yes, please list the allergy and reaction?

____

Have you had any adverse reactions to immunizations? Yes No

If yes, which immunization and what was the reaction?

____

FAMILY HISTORY

Does anyone in your child's family have any of the following conditions. If yes, who?

Cancer: ____

Diabetes: ____

Hypertension: ____

Hyperthyroidism: ____

Hypothyroidism: ____

Cataracts: ____

Macular Degeneration: ____

Glaucoma: ____

DEVELOPMENTAL HISTORY

Was your child adopted? Yes No

Was your child: Full Term Premature (Under 37 Weeks)

Birth Weight: __________ lbs., __________ oz

Were there any complications at birth?

Toxemia Trauma Alcohol Use Drug Use C-Section Severe Illness

If yes to any, please explain: ____

Did your child crawl? Yes No

If yes, at what age? ____________________ For how long? ________________

Did your child walk: Early (Before 11 months) On Time Late (After 14 months)

Did your child move any other way other than crawling? Yes No

If yes, please describe:

____

Are your child gross motor skills: Normal Below Normal

Are your child fine motor skills: Normal Below Normal

Which hand is your child's dominant hand? Right Left

At what rate did your child's speech develop? Normal (Before 18 months)

Delayed (After 18 months)

BRAIN INJURY HISTORY

Has your child sustained a brain injury? Yes No If yes, when? ____________________

How did the injury happen? ____

What other treatment(s) has your child received for their brain injury?

____

VISUAL HISTORY

Date of last eye examination: ____________________ Doctor's Name: _________________________

Were you prescribed: Glasses Contacts

Prescribed for: Full-Time Wear Distance Only Near Only

Have the following vision problems been diagnosed?

- Amblyopia (Lazy Eye): Yes No
- If yes, have you received treatment: ____
- Strabismus (Eye Turn): Yes No
- If yes, have you received treatment: ____
- Which eye turns: Left Eye Right Eye Both Eyes
- Did the eye turn start: Suddenly Gradually
- Which direction does the eye turn: In Out Up Down

Vision Symptom Survey

Please complete the following checklist to the best of your ability.

	NEVER (1)	SELDOM (2)	OCCASIONALLY (3)	FREQUENTLY (4)	ALWAYS (5)
Blurred close vision					
Double vision					
Headaches with near work					
Words run together while reading					
Burning, itchy, or watery eyes					
Sees worse at the end of day					
Skipping/repeating lines while reading					
Dizzy/nauseated by near work					
Tilting head or closing one eye when reading					
Difficulty copying from a chalkboard					
Avoiding near work or reading					
Omitting small words when reading					
Writing uphill or downhill					
Misaligning digits/columns of numbers					
Poor reading comprehension					
Holding books or near work very close to eyes					
Short attention span with near work					
Difficulty completing assignments on time					
Saying "I can't" before trying something					
Clumsiness and knocking things over					
Poor time use/management					
Forgetfulness/poor memory					
Car or motion sickness					
Does not make change well					
Does not judge distance accurately					
Poor handwriting					
Avoids sports/games					