Child Demographics

Patient Name: ____ DOB:__________ Grade:__________

Do you prefer your child not be in the room while discussing the history/concerns and/or my findings? □Yes □No

Address: ____

Parent 1 Information

Name: ____________________________________ Occupation: ______________________________

Home Phone: _______________________________ Cell Phone: ______________________________

Work Phone: _______________________________ Email: ___________________________________

Preferred way to contact you regarding appointments, billing or health related information: ___________________

Would you like to sign up to receive our monthly e-newsletters (we never give out emails)? □Yes □No

Address (if different from above): ____

Parent 2 Information

Name: ____________________________________ Occupation: ______________________________

Home Phone: _______________________________ Cell Phone: ______________________________

Work Phone: _______________________________ Email: ___________________________________

Preferred way to contact you regarding appointments, billing or health related information: ___________________

Would you like to sign up to receive our monthly e-newsletters (we never give out emails)? □Yes □No

Address (if different from above): ____

Names of Siblings	Age	Names of Siblings	Age
________________	______	________________	______
________________	______	________________	______
________________	______	________________	______

Whom can we thank for referring you? ____

Visual History

Date of last vision exam: ________________________ Doctor: ______________________________

Reason for exam: ___________________________ Were glasses/contacts prescribed? □Yes □No

If yes, are they worn? □Yes □No □Sometimes When? ______________________________

Is there a history of eye crossing or turning? □Yes □No How often? □Frequently □Occasionally □Rarely

Which eye? □Right □Left □Alternates When did you first notice the problem? ____________________

Has your child ever received vision therapy or patched an eye? □Yes □No

If yes, details: ____

Was surgery performed? □ Yes □No When? ____________________ Results: ____________________

Family History of:

□ Glaucoma □ High Refractive Error □ Cataract □ Lazy Eye/Amblyopia

□ Migraines □ Learning Disabilities □ Eye Turn/Strabismus

Please explain: ____

____

____

Developmental History

Full term pregnancy? □Yes □No Birth Weight: ________________

Complications before/after birth: ____

At what age did your child begin: Sit unsupported _____________Crawl ___________Walk ____________

Did your child exhibit a normal cross-pattern crawl? □Yes □No

Does/Did your child have any delays in speech/language? □Yes □No

If yes: Receptive Expressive Please explain: ____

How would you describe your child's gross motor skills for his/her age? (i.e.: running, jumping, skipping, etc.)

Very Poor Poor Average Above Average ____

Does your child have difficulty navigating stairs? □Yes □No Playground equipment? □Yes □No

How would you describe your child's fine motor skills for his/her age? (i.e.: tying shoes, cutting, writing, etc.)

Very Poor Poor Average Above Average ____

Has your child been diagnosed with any of the following:

CP Down's Syndrome ADD/ADHD Autism PDD Sensory Processing Disorder

Does your child have trouble with social skills? No Mild Moderate Severe

Does your child have trouble following multi-step directions? No Mild Moderate Severe

Does your child have a fear of doctors? □Yes □No

Does your child have separation anxiety? □Yes □No

Does your child have a fear of new situations? □Yes □No

Please describe any other delays or concerns with your child's development: ____

Medical History

Briefly describe your child's physical condition: ____

Most recent medical exam: ________________________ Doctor's Name: ______________________________

Results: ____

List any medications your child is using and for what conditions: ____

Does your child experience headaches? Yes No Rarely

If yes, how often? ___________________________________ How severe? ______________________________

Where is the pain located? ____

Has your child had any injuries to the eye(s)? □Yes □No Head? □Yes □No Spine? □Yes □No

If yes, please explain: ____

Has your child had a neurological evaluation? □Yes □No By whom? ______________________________

Results: ____

Has your child ever had occupational therapy? □Yes □No By whom? ______________________________

When? ___________________________________ For what? ______________________________

Results: ____

Has your child ever had physical therapy? □Yes □No By whom? ______________________________

When? ___________________________________ For what? ______________________________

Results: ____

Has your child ever had speech therapy? □Yes □No By whom? ______________________________

When? ___________________________________ For what? ______________________________

Results: ____

Any additional therapies you have tried and with what success?____

Academic History

Type of school: Home Public Private Grade: ___________________

Name and address of school: ____

Age at time of entrance to kindergarten: ________________________ First Grade: ___________________

Does your child like school? □Yes □No □Sometimes

Does your child like the teachers? □Yes □No □Sometimes

Does your child have an IEP (Individualized Educational Plan)? □Yes □No

Does your child have a 504 plan? □Yes □No

Please bring any IEP's, 504's, or other related testing to appointment

How is your child performing in school?

Reading	> 2 years behind	Below Average	Average	Above Average
Mathematics	> 2 years behind	Below Average	Average	Above Average
Spelling	> 2 years behind	Below Average	Average	Above Average
Writing	> 2 years behind	Below Average	Average	Above Average
Handwriting	> 2 years behind	Below Average	Average	Above Average

Has a grade been repeated? □Yes □No If yes, which and why? ____

Has your child received tutoring and/or remedial assistance? □Yes □No

From? __________________________________ How long? ____

Results: ____

Has your child ever had special educational or psychological testing? □Yes □No

By whom? ____

Results: ____

Do you feel your child is working up to his/her potential? □Yes □No □Unsure

Do the teachers feel your child is working up to his/her potential? □Yes □No □Unsure

Which school subjects are easiest for your child? ____

Which school subjects are most difficult for your child? ____

Does your child like to read? □Yes □No Write? □Yes □No Draw? □Yes □No

Does your child like to participate in Physical Education/Sports? □Yes □No

Describe any other school difficulties or concerns not listed: _______________________________________

____

____

Extra Curricular Activities

On average, how many hours per day does your child participate in the following activities:

	Weekdays	Weekends
T.V. Viewing	__________	__________
Computer/Tablet Work	__________	__________
Video Game Playing	__________	__________
Handheld Video Game Playing	__________	__________

Please list any sports, music, or other activities your child is involved in: ________________________________

____

____

____

Review of Systems

Constitutional
- Developmental Disability ☐
- Cancer ☐
- Fatigue ☐
- Fever ☐
- Other:_________________
- None ☐

Ear/Nose/Throat
- Hearing Loss ☐
- Chronic sinus problem ☐
- Tubes in ears ☐
- Earaches or drainage ☐
- Other:_________________
- None ☐

Neurological
- Multiple Sclerosis ☐
- Epilepsy ☐
- Cerebral Palsy ☐
- Migraine ☐
- Other:_________________
- None ☐

Psychiatric
- Depression ☐
- ADD/ADHD ☐
- Panic Disorder ☐
- Schizophrenia ☐
- Other:_________________
- None ☐

Cardiovascular
- Hypertension ☐
- Heart Disease ☐
- Vascular Disease ☐
- Stroke ☐
- Other:_________________
- None ☐

Respiratory
- Cigarette Smoke ☐
- Asthma ☐
- Bronchitis ☐
- Emphysema ☐
- Other:_________________
- None ☐

Gastrointestinal
- Crohn's Disease ☐
- Colitis ☐
- Ulcers ☐
- Change in appetite ☐
- Other:_________________
- None ☐

Musculoskeletal
- Osteoarthritis ☐
- Fibromyalgia ☐
- Muscular Dystroph ☐
- Osteoporosis
- Other:_________________
- None ☐

Skin
- Eczema ☐
- Rosacea ☐
- Psoriasis ☐
- Ringworm ☐
- Other:_________________
- None ☐

Endocrine
- Diabetic (non-insulin dep.) ☐
- Diabetic (insulin dep.) ☐
- Thyroid Dysfunction ☐
- Hormonal Dysfunction ☐
- Other:_________________
- None ☐

Hematological/Lymphatic
- Anemia ☐
- Hemophilia ☐
- Leukemia ☐
- Enlarged glands ☐
- Blood transfusions ☐
- Other:_________________
- None ☐

Allergies
- Drug ☐
- Environmental ☐
- Rheumatoid Arthri ☐
- Lupus ☐
- Other:_________________
- None ☐

Please list any known allergies: ______________________

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Near-Work Stress Questionnaire

Please check the box that best matches your observations.

How often does each behavior occur	Never (0)	Seldom (1)	Occasionally (2)	Frequently (3)	Always (4)
Your eyes feel tired when reading or doing close work					
Your eyes feel uncomfortable when reading or doing close work					
You have headaches when reading or doing close work					
You feel sleepy when reading or doing close work					
You lose concentration when reading or doing close work					
You have trouble remembering what you have read					
You have double vision when reading or doing close work					
You see the words move, jump, swim, or appear to float on the page when reading or doing close work					
You feel like you read slowly					
Your eyes ever hurt when reading doing close work					
Your eyes ever feel sore when reading or doing close work					
You feel a “pulling” feeling around your eyes when reading or doing close work					
You notice the words blurring or coming in and out of focus when reading or doing close work					
You lose your place when reading or doing close work					
You have to reread the same line of words when reading					
Total Score ___________	**__x 0**	**__x 1**	**__x 2**	**__x 3**	**__x 4**

COVD- Quality of Life Checklist

Please check the box that best matches your observations.

Question	Never (0)	Seldom (1)	Occasionally (2)	Frequently (3)	Always (4)
Headaches with near work					
Words run together when reading					
Burn, itch, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Says I can't before trying					
Clumsy, knocks things over					
Does not use time well					
Loses belongings/things					
Forgetful/poor memory					
Total Score ____________	__x 0	__x 1	__x 2	__x 3	__x 4