VISUAL PROCESSING OPTOMETRY

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PLEASE COMPLETE BOTH SIDES OF THIS FORM FOR PATIENTS UNDER 18 YEARS

PATIENT'S NAME_____ DOB _____ Phone_____

If applicable: Gender assigned at birth_____ Gender Identity_____ Preferred Pronouns_____

Address _____City_____Zip Code_____

School_____ Grade_____ SS#_____

Address/City/ZIP_____School Phone_____

WHO REFFERED YOU TO OUR OFFICE?_____

PARENT NAME_____Mobile Phone_____Home Phone_____

Preferred Pronouns_____DOB_____ SS #_____-____-_____ Check if parenting apart____

Address (if different than above)_____

Vision Insurance Name_____Member Name_____Member ID #_____

PARENT NAME_____Mobile Phone_____Home Phone_____

Preferred Pronouns_____DOB_____ SS#_____-____-_____ Check if parenting apart____

Address (if different than above)_____

Vision Insurance Name_____Member Name_____Member ID #_____

Family email: _____

EMERGENCY CONTACT_____**RELATIONSHIP**_____**PHONE**_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____ Relationship_____

Address (if different from above)_____Phone_____

What is the reason for this exam?_____

Please list any medications/supplements/homeopathics your child takes and the dosages_____

WHICH OF THE FOLLOWING PERFORMANCE SYMPTOMS APPLY TO YOUR CHILD?

__Loses place when reading	__Distorted posture when reading and writing
__Uses finger to keep place when reading	__Squints or rubs or covers eye when reading
__Omits small words when reading	__Poor handwriting skills
__Confuses small or simple words	__Poor at sports, clumsiness
__Holds book too close when reading	__Short attention span
__Avoids doing close work, reading, writing	__Daydreams during school/homework
__Reversals when reading (was for saw, on for no)	__Reversals when writing (b for d, p for q)
__Transposition of letters and numbers 21 for 12)	__Poor at spelling
__Does not perform up to his/her potential	__Poor self esteem
__Moves head when reading	__Poor comprehension
__Fails to recognize the same word in next sentence	__Poor copying from chalkboard
__Fatigue, frustration, stress	__Responds to new tasks with "I can't"
__Slow at completing assignments/work	__Struggling in school

Other_____

Have you been told your child has _____ADD _____ADHD _____Dyslexia _____Other learning disabilities?_____
Received any special tutoring and/or remedial assistance? From whom_____
Where_____ When_____ Duration_____
Results_____

Name_____**File #**_____**Date**_____

VISUAL HISTORY:

Name of previous eye doctor_____Date of last exam_____Date of last glasses_____

Have there been any eye injuries and/or surgeries? Please describe_____

Please check any of the following areas in which your child or a blood relative have had a problem or condition:

	Child	Family		Child	Family		Child	Family
Blindness	( )	( )	Glaucoma	( )	( )	Headache	( )	( )
Retinal detachment	( )	( )	Dry eyes	( )	( )	Cataracts	( )	( )
Distorted vision	( )	( )	Macular degeneration	( )	( )	Red eyes	( )	( )
Double vision	( )	( )	Watery eyes	( )	( )	Eye pain/soreness	( )	( )
Blurred vision	( )	( )	Chronic eye infections	( )	( )	Burning sensation	( )	( )
Crossed/turned eye	( )	( )	Styes	( )	( )	Sandy/gritty feeling	( )	( )
"Lazy eye"	( )	( )	Halos	( )	( )	Glare/light sensitive	( )	( )
Flashes/Floaters	( )	( )	Other symptoms/problems_____					

Has your child had or been recommended to have Vision Therapy? If yes, please indicate when and with whom._____

_____

MEDICAL HISTORY:

Name of physician_____Last exam__ _____Is your child generally healthy?_____

	Child	Family		Child	Family
Allergies			**Hematological**		
Hay fever	( )	( )	Anemia	( )	( )
Medications (indicate reaction)	( )	( )	Bleeding problems	( )	( )
Cardiovascular			**Immunological**		
Heart disease	( )	( )	Auto-immune disease	( )	( )
Vascular disease	( )	( )	Rheumatoid arthritis	( )	( )
Respiratory			Multiple sclerosis	( )	( )
Shortness of breath	( )	( )	Other: _____	( )	( )
Asthma	( )	( )	**Skin**		
Emphysema	( )	( )	Eczema	( )	( )
Ear/Nose/Mouth/Throat			Psoriasis	( )	( )
Sinus problems	( )	( )	**Musculoskeletal**		
Tonsillitis	( )	( )	Arthritis	( )	( )
Chronic ear infections	( )	( )	Muscle/Joint pain	( )	( )
Ear tubes	( )	( )	**Neurological**		
Endocrine			Headaches/Migraines	( )	( )
Diabetes Type 1 or 2 (circle)	( )	( )	Seizures	( )	( )
Thyroid problems	( )	( )	**Psychiatric**		
Other glands	( )	( )	Panic attacks	( )	( )
Gastrointestinal			Depression	( )	( )
Diarrhea/Constipation	( )	( )	Compulsive disorder	( )	( )
Ulcers	( )	( )	**Genitourinary**		
			Kidneys	( )	( )
			Bladder	( )	( )

Please list any illnesses, high fevers, bad falls or medical conditions that were not covered in the above list._____

_____

Please list any specific treatments or surgeries your child has had._____

Has your child ever been exposed to or infected with:___ Hepatitis ____HIV ____Herpes ____Gonorrhea ___Syphilis

I authorize the release of reports/examination records (please initial): YES_____ NO_____

_____ ***I understand that I am responsible for ALL charges incurred in the office and that payment is due at the time of service. Billing of insurance companies (except certain restricted VSP programs) is my responsibility.***

_____ ***I understand that I will be charged for any appointments missed or cancelled less than 24 hours in advance.***

Print Name_____Signature_____Date_____

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