

Today's Date _____ Patient's Name _____

Account # _____ Patient # _____ Grade Level _____

D.O.B. _____

CHILDREN'S INFORMATION FORM

Check the following that apply to your child (complaint of child or noticed by others).

- | | | |
|--|---|---|
| <input type="checkbox"/> Distance vision blurred | <input type="checkbox"/> Reads close | <input type="checkbox"/> Not working to potential |
| <input type="checkbox"/> Near vision blurred | <input type="checkbox"/> Tilts or turns head to read | <input type="checkbox"/> Frustrates easily |
| <input type="checkbox"/> Slow focus shift to/from chalkboard | <input type="checkbox"/> Poor posture when reading | <input type="checkbox"/> Attempts tasks with little success |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Closes or covers eye to read | <input type="checkbox"/> Easily fatigued |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Uses finger to read | <input type="checkbox"/> Behavior problems in school |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skips words | <input type="checkbox"/> Bumps into things |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Poor eye movement | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Squinting | <input type="checkbox"/> Reduced comprehension | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Rubbing eyes | <input type="checkbox"/> Cannot recognize words | <input type="checkbox"/> Eye surgery |
| <input type="checkbox"/> Eyes turn | <input type="checkbox"/> Reversals of numbers & letters | <input type="checkbox"/> Reads well |

PLEASE RATE THE PATIENT'S CURRENT LEVELS IN THE FOLLOWING AREAS:

	Special Program Or Tutoring	Poor	Average	Good	Grade Level Achieved
Reading (average hours/day)					
Comprehension					
Math					
Spelling					
Handwriting					
Behavior					
Likes School					
Likes Sports (average hours/day)					
Balance					
Running					

GENERAL HEALTH AND DEVELOPMENT:

- | | | |
|---|--|---|
| <input type="checkbox"/> Illness during pregnancy | <input type="checkbox"/> Instrument birth | <input type="checkbox"/> Eye or head injuries |
| <input type="checkbox"/> Medications during pregnancy | <input type="checkbox"/> Complications after birth | <input type="checkbox"/> High Sugar diet |
| <input type="checkbox"/> Injuries during pregnancy | <input type="checkbox"/> Severe childhood illness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Premature | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma in family |
| <input type="checkbox"/> Unusual birth weight | | |