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).

____ Distance vision blurred
____ Near vision blurred
____ Slow focus shift to/from chalkboard
____ Double vision
____ Eye Strain
____ Headaches
____ Red Eyes
____ Squinting
____ Rubbing eyes
____ Eyes turn

____ Reads close
____ Tilts or turns head to read
____ Poor posture when reading
____ Closes or covers eye to read
____ Uses finger to read
____ Skips words
____ Poor eye movement
____ Reduced comprehension
____ Cannot recognize words
____ Reversals of numbers & letters

____ Not working to potential
____ Frustrates easily
____ Attempts tasks with little success
____ Easily fatigued
____ Behavior problems in school
____ Bumps into things
____ Poor coordination
____ Light sensitivity
____ Eye surgery
____ 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:

____ Illness during pregnancy
____ Medications during pregnancy
____ Injuries during pregnancy
____ Premature
____ Unusual birth weight

____ Instrument birth
____ Complications after birth
____ Severe childhood illness
____ Allergies

____ Eye or head injuries
____ High Sugar diet
____ Speech problems
____ Glaucoma in family