Insight Family Eye Care

Vision Therapy Registration Form

General Information

Patient Name:	**Date of Birth**	**Age:**
Street Address	**City and State**	**Zipcode**
Home Phone #	**Cell #:**	
Child's School:	**Grade:**	**Teacher:**
By whom were you referred to us?	**Reason for Referral:**	
What is your child experiencing difficulties with?		
How long has the difficulty been noticed?		

Previous Eye Exam

Reason for Exam:	**Doctor's Name**	**Date:**

Result of Exam:

Is your child afraid of doctors? _____Yes _____No	**Your child's handedness? _____Right Hand _____ Left Hand**

Parent/Family Information

Father/Guardian Name:	**DOB:**	**Occupation:**	**Phone Number:**
Mother/Guardian Name:	**DOB:**	**Occupation:**	**Phone Number:**
Sibling Name:	**DOB:**	**Age:**	**Sex:**
Sibling Name:	**DOB:**	**Age:**	**Sex:**

Sibling Name:	DOB:	Age:	Sex:
Is the child adopted? _____Yes _____No		If yes, does the child know?	Age when adopted? _____

Child's Medical History

Date of Child's last physical exam:	
Name of Child's Pediatrician:	
List any current medications your child takes:	
List any medical conditions your child has:	

Has your child ever had any severe falls or illnesses?

- ❑ Yes
- ❑ No

If so, please list and describe (Age, Date, Severity, Illness, Complications)

Has your child been vaccinated?	Are you up to date on your child's vaccinations?
❑ Yes ❑ No	❑ Yes ❑ No

Is your child generally healthy? _____ Yes _____No If no, please explain.

Are there any chronic problems i.e. ear infections, asthma, allergies? _____Yes _____No

If yes, please list:

Please check the following behaviors as they relate to your child

❑ Eyes turn in or out ❑ Rubs eyes often ❑ Dislikes bright lights ❑ Doesn't have any interest in looking at objects ❑ Blurry vision ❑ Tilts head when reading ❑ Burning, itching, irritated eyes when reading or writing	❑ Red eyes or eyelids ❑ Knocks things overs ❑ Stares at bright objects ❑ Sits close to the TV ❑ Reads below grade level ❑ Difficulty copying from the board ❑ Does not comprehend when reading ❑ Homework takes longer than average	❑ Headaches ❑ Runs into things ❑ Holds items close to look at them ❑ Words slide together ❑ Loses place when reading ❑ Doesn't like to read/write ❑ Difficulty finishing assignments on time ❑ Does not focus well at school/stays off task

Developmental History

Weight at Birth	Was the Pregnancy Full Term? ❑ Yes ❑ No If no, length of pregnancy?	Were any medications taken during pregnancy? ❑ Yes ❑ No If yes, what medications?

Were there any complications before, during, or after labor? ❑ Yes ❑ No If so, please explain:	Was there ever any concern over the overall development of your child? ❑ Yes ❑ No If so, please explain

Please indicate with an "x" or a check when your child was able to accomplish the following tasks:

	Early	On Time	Late	Has not Accomplished
Smile in response to you				
Laugh				
Roll over				
Try to grab an object				
Creep on belly				
Crawl on hands and knees				
Respond to his/her name				
Say his/her name				
Walk by themselves				
Use silverware				
Walk up stairs				
Use more than one word in a sentence				
Potty Trained				

Dietary Habits

Did you nurse?	Formula fed?	At what age did your child start eating solid food?	Does your child have any food allergies?
❑ Yes ❑ No, never ❑ Currently ❑ From _____ to _____	❑ Yes ❑ No, never ❑ Currently ❑ From _____ to _____		❑ Yes ❑ No If so, what foods?

Family History

Please check the box if anyone in your immediate family has or has had any of the following conditions:

❑ Diabetes ❑ Respiratory Problems ❑ Skin Disease ❑ Glaucoma	❑ High Blood Pressure ❑ Thyroid Condition ❑ Migraines ❑ Macular Degeneration	❑ Heart Problems ❑ High Cholesterol ❑ Psychiatric Disease ❑ Lazy Eye ❑ Other:

Does anyone in the family (mother/father/sibling) have a learning problem? _____Yes _____No
Has your child ever been through a traumatic family situation (i.e. divorce, parental loss/death, separation)?
_____Yes _____No If yes, at what age was your child? _____
Does your child seem to have adjusted? _____Yes _____No
Is family life stable at this time? _____Yes _____No

School Information

Is your child enrolled in daycare? _____Yes _____No
If your child is in school, what grade is he/she in? _____
Has your child ever had to repeat a grade? _____Yes _____No If yes, which grade? _____
Does your child like school? _____ Yes _____No
Is school work? _____ Below Average _____ Average _____Above Average
What is your child's favorite subject? _____ Least Favorite Subject? _____
What subjects are considered the easiest? _____
What subjects are considered difficult?_____
Have there been any school difficulties?_____
Does test taking appear to cause anxiety? _____Yes _____No
Does the school consider your child to have a learning problem? _____Yes _____No
Does the school consider your child to have a discipline problem? _____Yes _____No
Does your child like to read? _____Yes _____No
Do you feel your child is achieving up to his/her potential? _____Yes _____No
Does your child's teacher(s) feel like he/she is performing up to their full potential? _____Yes _____No
What is your child's attitude toward school, reading, or learning? _____
_____
_____

Does your child receive or is in any of the following?

❑ **Special Education program**

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- ❑ **Speech Therapy**
- ❑ **Occupational Therapy**
- ❑ **Physical Therapy**
- ❑ **Tutoring By Whom?_____**
- ❑ **Remedial Assistance**

Does your child have an Individualized Education Plan (IEP) or a 504 Plan?

- ❑ **Yes**
- ❑ **No**

If so, please briefly summarize your child's plan below:

Has your child ever been diagnosed with ADD/ADHD? _____Yes _____No

Please describe your child's personality and behavior to the best of your ability.

Is there anything else you would like for us to know about your child? If so, please describe below.

Thank you for taking the time to fill out this form. Getting to know your child and the extent of their vision problem is very important to us! By taking the time to fill out this form you have ensured that we have the right information, along with the doctor's findings, to identify the vision problem at hand so we can start working on a resolution!

Would you like your child's pediatrician, teacher or another healthcare provider to receive a copy of the results of your child's evaluation today? If so, please fill out the information at the bottom and sign and date the release form. Thank you so much!!

Who would you like to send the report to?

Name:	**Address**	**Phone:** **Fax:**
Name:	**Address:**	**Phone:** **Fax:**
Name:	**Address:**	**Phone:** **Fax:**
If you are the parent or guardian, please sign here acknowledging your consent to have your child's report sent to the above persons. Thank you _____ **Parent or Guardian Signature**		**Date:**

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