VISION THERAPY EVALUATION

PATIENT NAME ___________________________

PATIENT DATE OF BIRTH ____ /____ /_________

PATIENT'S CURRENT GRADE _____

DATE OF EVALUATION ____ /____ /_________

PERSON ACCOMPANYING PATIENT ___________________________

CONTACT PHONE NUMBER (_______) _______ - _________

CONTACT EMAIL ___________________________

PLEASE CONTACT US VIA: ○ PHONE ○ TEXT ○ EMAIL

HOW DID YOU HEAR ABOUT US? ○ CURRENT PATIENT ○ REFERRAL ○ INTERNET SEARCH ○ DRIVE BY ○ OTHER

THE REASON I AM SEEKING AN EVALUATION FOR MY CHILD IS:

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SYMPTOM HISTORY

Please indicate if your child has any of the following symptoms:

Symptom	YES	NO
Skips lines/words when reading	O YES	O NO
Avoids reading or near work	O YES	O NO
Holds paper or tablet close to face	O YES	O NO
Reverses letters and/or numbers	O YES	O NO
One eye turns or wanders	O YES	O NO
Double vision	O YES	O NO
Headaches with near work	O YES	O NO
Poor handwriting	O YES	O NO
Tilts head or closes one eye	O YES	O NO
Says words without reading them	O YES	O NO
Difficulty copying from the board	O YES	O NO
Difficult to understand speech	O YES	O NO
Does not remember what he/she read	O YES	O NO
Poor eye-hand coordination	O YES	O NO
Words run together or blur	O YES	O NO
Responds better to verbal instruction	O YES	O NO
Poor time management	O YES	O NO

VISUAL HISTORY

Has your child's vision been previously evaluated? O YES O NO

If *YES*, date of last eye exam: ________________

Doctor's name: ______________________

Doctor's phone: _____________________

Results/ recommendations: _____________________________________

Has your child been prescribed glasses or contact lenses in the past? O YES O NO

If *YES*, how often does he/she wear visual correction?

O ALL TIMES O SPECIFIC ACTIVITIES O RARELY

Do you feel the visual correction is helpful for your child? O YES O NO

Do you feel your child should wear correction more/less often?

If *YES*, please explain. ____

DEVELOPMENTAL HISTORY

Did the child's mother experience any health problems during pregnancy? O YES O NO

If *YES*, explain: ____

Was the pregnancy with your child full-term? O YES O NO

Was oxygen used after birth? O YES O NO

Birth weight: _____ lb. _____ oz. Apgar scores @ birth:______ 10 min:_______

Were there any complications before, during, or after delivery? O YES O NO

If *YES*, explain: ____

Has there ever been concern about your child's growth/ development? O YES O NO

If *YES*, why? ____

Did your child crawl (stomach on floor)? O YES O NO If *YES, a*t what age? ________

At what age did your child begin to walk? _________

Has your child ever been under general anesthesia? O YES O NO

If *YES,* how many times/at what ages? ______________________________________

Child's dominant hand: O RIGHT O LEFT

MEDICAL HISTORY

Pediatrician's Name: ___________________________ Date of Last Evaluation: _________

Results and recommendations: ____

Medications currently using, including vitamins and supplements:

____

For what condition(s)? ____

____

Have any of the following evaluations ever been performed?

Neurology	By whom/when? _____________________________________
General Psychology	By whom/when? _____________________________________
Academic Psychology	By whom/when? _____________________________________
Occupational Therapy	By whom/when? _____________________________________
Physical Therapy	By whom/when? _____________________________________
Speech Therapy	By whom/when? _____________________________________
Chiropractor	By whom/when? _____________________________________

Do you feel your child may need a referral for one of the above-listed evaluations? If *YES*, please explain.

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Is your child *currently* undergoing any therapies/treatments? If *YES*, please describe.

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ACADEMIC HISTORY

Current school: ____

Teacher: ___________________________ School Nurse: ___________________________

Has a grade been repeated? O YES O NO

If *YES*, which and why? ____

Has your child had any tutoring, therapy, and/or remedial assistance? O YES O NO

Where/ from whom? ____

Does your child like school? O YES O NO

Does your child seem tense/ under pressure when doing schoolwork? O YES O NO

Overall schoolwork is: O ABOVE AVERAGE O AVERAGE O BELOW AVERAGE

Please list the areas where your child is performing:

Above average ____

Average ____

Below average ____

Does it seem like your child need to spend a lot of time/effort to maintain this level of performance? O YES O NO

How much time on average does your child spend each day on homework assignments? __________

Does your child like to read? O YES O NO

Does your child read for pleasure? O YES O NO
Do you feel your child is achieving up to potential? O YES O NO
Does the teacher(s) feel your child is achieving up to potential? O YES O NO
Briefly describe any other school difficulties or concerns:

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BEHAVIORAL HISTORY

Are there any behavior problems at school or home? O YES O NO
If *YES*, what? ____
What triggers these problems? ____
What is your child's reaction to fatigue or tension?
O AVOIDANCE O ANGER O SADNESS O OTHER
Which of the following describes your child *best*:
O My child says or does things quickly and impulsively
O My child is very cautious and slow to respond
Which of the following describes your child *best*:
O My child is observant and/or detail oriented
O My child is not observant/ does not notice details
Which of the following describes your child *best*:
O My child is in constant motion
O My child can sit still for long periods of time
My child responds most positively to:
O Verbal praise (ie: "Good job!" or "Great work!")
O Physical rewards (ie: stickers, candy, or gifts)
O Activity rewards (ie: outdoor playtime or video game time)
My child is happiest when he/she is: ____
Please list any of your child's specific interests: ______________________________

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Please describe any concerns about your child's learning, development, or behavior.

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Please list any other comments that may be helpful in caring for your child.

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Thank you for carefully completing this questionnaire. The information supplied will allow us to perform a more comprehensive evaluation of your child to better meet your child's specific visual and/or medical needs.

Sincerely,

Susan A. Carter, O.D.
2053 Thunderhead Rd
Knoxville, TN 37922
www.nseyecare.com

RELEASE OF INFORMATION

It is often beneficial to discuss examination results/recommendations and to exchange information with your child's school and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers, or insurance carriers upon their written request or the recommendation of Dr. Susan when it is necessary. I authorize Dr. Susan Carter to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

____ ______________________

Signature (Relationship to Patient) Date