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:

_____

_____

_____

_____

_____

_____

_____

_____

SYMPTOM HISTORY

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

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

VISUAL HISTORY

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

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

○ ALL TIMES ○ SPECIFIC ACTIVITIES ○ RARELY

Do you feel the visual correction is helpful for your child? ○ YES ○ 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.

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

BEHAVIORAL HISTORY

Are there any behavior problems at school or home? ○ YES ○ NO

If *YES*, what? _____

What triggers these problems? _____

What is your child's reaction to fatigue or tension?

○ AVOIDANCE ○ ANGER ○ SADNESS ○ OTHER

Which of the following describes your child *best*:

○ My child says or does things quickly and impulsively

○ My child is very cautious and slow to respond

Which of the following describes your child *best*:

○ My child is observant and/or detail oriented

○ My child is not observant/ does not notice details

Which of the following describes your child *best*:

○ My child is in constant motion

○ My child can sit still for long periods of time

My child responds most positively to:

○ Verbal praise (ie: "Good job!" or "Great work!")

○ Physical rewards (ie: stickers, candy, or gifts)

○ 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: _____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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