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Student History Form

Patient's Name:_____ Goes by:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone: _____ Child's age:_____
Date of Birth: _____ Male_____ Female_____

Mother's Name: _____
Father's Name: _____
Guardians: _____
Child Resides With: _____

Mother's Occupation:_____
Cell Phone:_____
Work Phone:_____
Email Address:_____

Father's Occupation:_____
Cell Phone:_____
Work Phone:_____
Email Address:_____

School Name: _____
School Address: _____
_____
Teacher's Name: _____
Child's grade in school: _____

How did you hear about our office? _____

PRESENT SITUATION
Why do you wish to have your child evaluated? _____
_____
List any complaints your child makes concerning his/her vision: _____
_____
At what age did the problem being? Under what circumstances? _____
_____
Has the problem become better or worse? Explain. _____
_____
Does anyone else in the family have a similar problem? _____
_____

Has there been any previous treatment? _____

_____

Does your child feel that he/she has a problem? _____

If yes, what is the child's attitude towards the problem? _____

_____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, etc.

Illness/Injury	**Age**	**Severity**	**Complications (if any)**

List any prescription or over-the-counter medications being taken, dosage, reason _____

_____

_____

Health at the present time: Excellent _____ Good _____ Fair _____ Poor _____

Does your child suffer from any chronic problems (asthma, colds, allergies, ear infections)? _____

_____

VISUAL HISTORY

When was your child's last eye exam? _____

Clinic Name: _____

Clinic Address: _____

Were glasses recommended or prescribed? _____

Were treatment recommendations made? If yes, explain. _____

_____

Was the treatment plan followed (if applicable)? _____

Was the treatment plan effective (if applicable)? _____

Has Vision Therapy ever been recommended? _____

If yes, has the program been completed? _____

List any family members who have had vision treatment:

Name	**Age**	**Visual Condition**	**Treatment**

Are there any indications of hearing or speech-related problems? If yes, explain. _____

_____

_____

DEVELOPMENTAL HISTORY

Were there any complications during pregnancy? If yes, explain. _____

_____

List any medications taken during pregnancy. _____

_____

Length of pregnancy: _____ Natural or C-Section: _____

Were there any complications before, during, or after delivery? If yes, explain. _____

Did your child crawl with stomach on floor? _____If yes, at what age?_____
Did your child crawl on hands and knees? _____If yes, at what age?_____
Was there anything unusual about your child's crawling or early motor development? If yes, explain._____

At what age did your child walk? _____
Does your child require arm or leg braces for walking? _____
Which hand does your child use for: eating? _____Writing?_____Throwing?_____
Has he/she always used the same hand? _____
Was any guidance given on which hand to use? _____
Which foot does he/she use for: kicking? _____Hopping?_____
At what age did your child speak his/her first words? _____
Was early speech clear to others? _____
Is your child's speech clear now? _____

GENERAL BEHAVIOR

Does your child actively participate in play, sports, or athletics? If yes, which ones?_____

Does your child enjoy music? _____
Can your child carry a tune? _____
Can your child keep rhythm? _____
Are there any behavior problems? If yes, explain. What causes these problems?_____

EDUCATIONAL HISTORY

What was your child's age at time of entrance into: Kindergarten _____1st grade:_____
Does your child like school? _____
Does your child like his/her teacher? _____

Your child's school work is: Above Average_____Average_____Below average___Well below average____
Do you feel that your child is working up to his/her potential? _____
Describe any school difficulties. List possible reasons you have for these difficulties._____

What subjects are easy for your child? _____
What subjects are difficult for your child? _____
Has a grade been repeated? If yes, which grade? _____
Does your child attend special needs classes? If yes, explain _____

Has attendance been regular? If no, explain. _____
Does your child like to read? _____
Does your child read voluntarily? If yes, what?_____
Does your child prefer to be read to rather than reading on his/her own? _____

Has your child ever been classified ADD, ADHD, LD, dyslexic or any other diagnosis? If yes, which one(s)?___

List any psychological or educational tests performed:

HOME ENVIRONMENT

List anyone who lives at home with your child.

Name	Age	Gender	Relationship to the child

Is there any additional information that we should know? (frequent moving, separation, divorce, remarriage, death, etc.) _____

List previous nursery or other group experiences (Sunday school, camp, daycare, etc.)_____

INTERESTS AND HOBBIES

Does your child have any special abilities? (art, music, etc.) _____

What activities does your child find most rewarding or enjoy the most? _____

Give a brief description of your child's personality. _____

Is there anything else you would like us to know? _____

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INNOVATIVE VISION IMPROVEMENT

Functional Vision Symptom Checklist

Patient Name: _____

Any of the following symptoms may indicate a functional vision problem. Please read and mark the symptoms that occur. This is a critical step in helping us understand the type and amount of functional vision problem that may exist. Check all that apply:

- ☐ Skip lines and / or words when reading or copying
- ☐ Lose place when reading or copying
- ☐ Substitute words when reading or copying
- ☐ Reread words or lines
- ☐ Reverse letters, numbers or words
- ☐ Confuse right and left directions
- ☐ Confuse similar words and letters
- ☐ Poor reading comprehension
- ☐ Difficulty remembering what you have read
- ☐ Comprehension decreasing the longer you read
- ☐ Hold head very close (within 7-8 inches) to reading and/or writing material
- ☐ Squint, close or cover one eye when reading
- ☐ Tilt head in an unusual posture when reading or writing
- ☐ Use a finger or marker to keep place when reading or writing
- ☐ Read very slowly
- ☐ Experience headaches after intense visual activities (reading or computer work)
- ☐ Eyes hurt or feel tired after close work
- ☐ Feel unusually tired after completing a visual task
- ☐ Vision blurs at a distance when looking up from near work
- ☐ Poor spelling skills
- ☐ Crooked or poorly spaced writing
- ☐ Misalign letters and numbers
- ☐ Make errors when copying
- ☐ Tend to lose awareness of surroundings when concentrating
- ☐ Dislike tasks requiring sustained concentration
- ☐ Mind wanders when reading
- ☐ Feel sleepy when reading
- ☐ Become restless when working at a desk
- ☐ Difficulty when tracking moving objects such as balls, etc.
- ☐ Must “feel” things to see them
- ☐ Unusual clumsiness or poor coordination
- ☐ Difficulty with activities requiring eye-hand coordination (sports such as baseball, etc.)
- ☐ Difficulty with activities requiring eye-body coordination (such as dancing, etc.)
- ☐ Carsickness or motion sickness

- ☐ Unusual blinking
- ☐ Unusual eye rubbing
- ☐ Experience symptoms of possible eye strain including:
    - ☐ Dry eyes
    - ☐ Watery eyes
    - ☐ Eyes are red
    - ☐ Eyes are frequently sore
    - ☐ Eyelid twitches
    - ☐ Sensitivity to light
- ☐ Difficulty using binoculars
- ☐ Difficulty judging distances
- ☐ Discomfort in crowded areas with excessive movement
- ☐ Eye turns in
- ☐ Eye turns out
- ☐ One eye sees more clearly than the other with best glasses prescription – Right eye or Left eye
- ☐ Double vision when reading
- ☐ Words or sentences are blurry or wiggly when reading
- ☐ Words or sentences come in and out of focus when reading
- ☐ Words “pop out” at you when reading
- ☐ Words “scrunch together”
- ☐ Words “pull apart” when reading
- ☐ Words move from side to side or up and down when reading
- ☐ Words move, jump, swim or appear to float on the page when reading