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## General Information

Were you referred to our office? Yes_____ No_____

If yes, whom may we thank for this referral?:_____

Patient's Full Name:_____Nickname:_____

Male or Female (please circle)

Birth Date:_____Age:_____years _____months

Grade:_____School:_____

## School Information

Current grade:_____ School:_____

Has a grade been repeated? Yes No (please circle) If so, why?_____

List any special help or remedial assistance your child gets at school:_____

Which subjects are below average?_____

How much time per day does your child spend on homework?_____

To what extent do you help your child with homework?_____

Do you feel your child is achieving up to their potential? Yes No (please circle)

Does the teacher(s) feel your child is achieving up to their potential? Yes No (please circle)

Please list any behavior problems at school:_____

## Family and Home

Please indicate which adult(s) the patient lives with (mother, father, step-parent, grandparent, etc:_____

Please list any behavior problems in the home:_____

Can your child sit still for long periods of time? Yes No (please circle)

## Medical History

Has a neurological evaluation been performed? Yes No (please circle)

By whom?_____

Results/recommendations:_____

Has a psychological evaluation been performed? Yes No (please circle)

By whom?_____

Results/recommendations:_____

Has occupational therapy, physical therapy, and/or speech therapy been performed? Yes No (please circle)

If yes, list specific therapies:_____

Therapist:_____

Results/recommendations:_____

## Developmental History

Full term pregnancy? Yes No (please circle)

Please list any health problems the mother experienced during pregnancy:_____

List any complications before, during, or immediately following delivery:_____

Birth weight:_____ Apgar score_____

Has there been any reason for concern over your child's general growth or development? Yes No (please circle)

If yes, why?_____

Did your child creep (stomach on floor)? Yes No (please circle) At what age?_____

Did your child crawl (on all fours)? Yes No (please circle) At what age?_____

If not, describe what movements were made:_____

At what age did your child walk?_____ Talk?_____

Was early speech clear to others? Yes No (please circle) Is it clear now? Yes No (please circle)

## Signs and Symptoms Reported (please circle)

**Focusing Deficiencies**

| | | |
|---|---|---|
| Blur or fluctuating vision at near point | Yes | No |
| Reports blurry vision at distance | Yes | No |
| Reports blurry vision at distance after near work | Yes | No |
| Reports eye fatigue after short periods of reading/writing | Yes | No |

| | | |
|---|---|---|
| Avoids near work | Yes | No |
| Eyes hurt, sting, burn, or tire while reading | Yes | No |
| Headaches or eye fatigue with near work | Yes | No |
| Excessive eye rubbing | Yes | No |

**Eye Point Deficiencies**

| | | |
|---|---|---|
| Squints, closes, or covers an eye during visual tasks | Yes | No |
| Reports that letters or words "jump" or move on the page | Yes | No |
| Abnormal posture when doing visual tasks | Yes | No |
| Intermittent double vision | Yes | No |
| Difficulty aligning columns or numbers | Yes | No |

**Eye Movement Deficiencies**

| | | |
|---|---|---|
| Excessive head movements when reading | Yes | No |
| Frequent loss of place when reading | Yes | No |
| Omits words of skips lines | Yes | No |
| Uses finger to keep place when reading | Yes | No |
| Lack of reading comprehension | Yes | No |
| Rereads lines unknowingly | Yes | No |

**Visual-Spatial Deficiencies**

| | | |
|---|---|---|
| Poor athletic performance | Yes | No |
| Lack of coordination or balance | Yes | No |
| Difficulty with rhythm | Yes | No |
| Clumsy, falls, and bumps into things | Yes | No |
| Difficulty learning right and left | Yes | No |
| Works only one side of the body | Yes | No |
| Letter and/or number reversals | Yes | No |
| Writes from right to left | Yes | No |

**Visual Analysis Deficiencies**

| | | |
|---|---|---|
| Trouble learning the alphabet | Yes | No |
| Confuses likenesses and differences | Yes | No |
| Trouble with basic math skills | Yes | No |

| | | |
|---|---|---|
| Mistakes words with similar beginnings | Yes | No |
| Difficulty recognizing the same word on a page | Yes | No |
| Trouble with main ideas in a story | Yes | No |
| Trouble writing and remembering letters/names/numbers | Yes | No |

**Visual Motor Deficiencies**

| | | |
|---|---|---|
| Difficulty copying from the board | Yes | No |
| Sloppy drawing, spacing, and writing skills | Yes | No |
| Inability to stay on lines | Yes | No |
| Erases excessively | Yes | No |
| Can respond orally but not in writing | Yes | No |
| Difficulty completing work in allotted time | Yes | No |
| Seems to know material but does poorly on test | Yes | No |
| Difficulty writing numbers in columns for math problems | Yes | No |

**Auditory-Visual Integration Deficiencies**

| | | |
|---|---|---|
| Poor spelling ability | Yes | No |
| Difficulty learning to read phonetically | Yes | No |
| Difficulty relating letters to their relevant sound | Yes | No |

**Please list any other problems or concerns related to your child that might be helpful or important during the treatment process:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewed by: OD initial_____ Date_____