McCULLEY Vision Therapy

GENERAL INFORMATION:

Child's name:_____ Goes by:_____

Male _ Female _ Date of birth:_____ Age: _____years ____months

Street Address:_____

City:_____ State:_____ Zip:_____

School Name and address:_____

Child's grade in school:_____ Teacher:_____

How did you hear about our Vision Therapy center?_____

Were you referred to our office? Yes _ No _

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

Mother's name: _____

Father's name: _____

Guardians: _____

Child resides with: _____ Home phone:_____

Mother: Occupation:_____

Cell phone:_____

Work phone:_____

e-mail address:_____

Father: Occupation:_____

Cell phone:_____

Work phone:_____

e-mail address:_____

PRESENTING CONCERNS:

Why do you wish to have your child evaluated? _____

_____ .

List any complaints your child makes concerning his/her vision: _____

_____ .

What age did the problem begin? Under what circumstances? _____

_____ .

Has the problem become better or worse? _____ Explain: _____

_____ .

Does/has anyone else in the family have/had a similar problem? _____

_____ .

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

Has there been any previous treatment? _____

_____ .

MEDICAL HISTORY:

Pediatrician's Name: _____ Clinic: _____

Medications child is taking (including over-the-counter and vitamins/supplements): _____

_____

For what conditions? _____

_____

List any illnesses, seizures, accidents, hospitalizations, surgeries, fevers, or serious medical issues your child has experienced?

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

_____

_____

_____

_____ .

Are there any chronic problems such as asthma, colds, allergies, or ear infections? _____

_____ .

Any indications of hearing or speech related problems? Yes _ No _ If yes, explain: _____

_____ .

Health at present: Excellent Good Fair Poor

DEVELOPMENTAL HISTORY:

Full term pregnancy? Yes _ No _ Length of pregnancy? _____

Any medications taken or health problems *during* the pregnancy? _____

_____ .

Delivery natural or C-Section?_____ Birth weight: _____ Apgar score: _____

Complications before, during, or following delivery? _____

_____

Did your child crawl (stomach on floor)? Yes _ No _ At what age? _____

Did your child creep (on all fours)? Yes _ No _ At what age? _____

Was there anything unusual about crawling or early motor development? _____

At what age did your child walk? _____ Arm/leg braces required? Yes _ No _

Speech: First words:_____ At what age? _____

Was early speech clear to others? Yes _ No _ Is speech clear now? Yes _ No _

Which hand does your child use for writing? **R / L** Eating? **R / L** Throwing? **R / L**

Has he/she always used the same hand? Yes _ No _ Was any guidance given? Yes _ No _

Which foot does he/she use for kicking? **R / L** Hopping? **R / L**

GENERAL BEHAVIOR:

Does he/she actively participate in playtime/sports/athletics? Yes _ No _

Which ones? _____

Which activities does your child enjoy? _____

Does he/she enjoy music? Yes _ No _

Can he/she carry a tune? Yes _ No _

Can he/she keep rhythm? Yes _ No _

Any behavior problems? Yes _ No _ If yes, explain: _____

_____ .

What causes these problems? _____

_____

EDUCATIONAL HISTORY:

Age at time of entrance to: Pre-school? ____ Kindergarten? ____ First grade? _____

Does your child like school? Yes _ No _ Does your child like the teacher? Yes _ No _

School work is: Above average Average Below average Well below average

Do you feel he/she is working up to his/her potential? _____

Does his/her teacher feel your child is working up to his/her potential? _____

Specifically describe any school difficulties: _____

_____ .

Possible reasons for difficulties? _____

_____

Has a grade been repeated? Yes _ No _ If yes, which grade? _____

Has school attendance been regular? Yes _ No _ If no, explain: _____

_____

Does your child attend any special need classes? Yes _ No _ If yes, explain: _____

_____

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes _ No _

If yes, where and from whom? _____

When? _____ How long? _____

Results: _____

Does your child like to read? Yes _ No _ Voluntarily? Yes _ No _

If yes, what? _____

Does your child prefer to be read to, rather than reading on his/her own? Yes _ No _

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

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

Has your child ever been classified as ADD, ADHD, LD or dyslexic? Yes _ No _

If yes, explain:_____

Please list any psychological or educational tests performed? _____

_____

_____

HOME & FAMILY:

Who lives in the home? Please give ages, gender, and relationship to the child:

Name **Age** **Gender** **Relationship to the child**

_____

_____

_____

_____

_____

Additional home information that your child has experienced (frequent moving, divorce, separation, remarriage, death, severe illness of a relative, etc.): _____

_____

_____

Has you child ever had counseling/therapy for emotional distress? Yes _ No _

If yes, is it on-going? Yes _ No _

Is family life stable at this time? Yes _ No _ If no, please explain: _____

_____

Child's reaction to fatigue (lethargic, irritable, etc)? _____

Child's reaction to tension (avoidance, irritable, etc)? _____

Does your child say and/or do things impulsively? Yes _ No _

Is your child in constant motion? Yes _ No _

Can your child sit still for long periods of time? Yes _ No _ If no, please explain: _____

_____

Do/did any parents/siblings have learning problems? Yes _ No _

If yes, who?_____ To what extent? _____

_____

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

_____

_____

VISUAL HISTORY:

Has your child's vision been previously evaluated? Yes _ No _

If yes, Doctor's Name:_____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

Were glasses /contact lenses/ any devices or treatments recommended? Yes _ No _

If yes, what? _____

Are they used? Yes _ No _ If yes, when? _____

If not used, why not? _____

Members of the family who have had visual conditions:

Name	**Age**	**Visual Situation or Diagnosis**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding my child and his/her current condition to my referring, consulting, or treating physicians.

Signature of Parent/Guardian:_____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. This Notice is available at your request. Your health information will be used only to treat you. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

Signature of Parent/Guardian:_____

FOR DOCTOR'S USE ONLY: This form was reviewed by: date: