South East Eyecare Intake Form – Vision Therapy (Child)

Today's Date (DD/MM/YY): _____ ****Please enter name as it appears on the health card****

First Name: _____ Last Name: _____ Date of Birth: _____
Form Completed By: _____ Relationship to Child: _____

Please complete all sections. The questions that are asked are all relevant to your child's vision therapy program, and the information you provide will be held in the strictest confidence.

Section I: Developmental History

Does your child have any developmental delays?	☐	No	☐	Yes	_____
Does your child have any language delays?	☐	No	☐	Yes	_____
Does your child have any hearing problems?	☐	No	☐	Yes	_____
Does your child have any physical disabilities?	☐	No	☐	Yes	_____
Does your child have poor coordination?	☐	No	☐	Yes	_____
Does your child understand "right" and "left"?	☐	No	☐	Yes	_____

Section II: Education History

School Attended: _____ Grade: _____ Teacher: _____

☐ Does not attend school ☐ Homeschooled ☐ French Immersion

Does your child enjoy school?	☐	No	☐	Yes	_____
Does your child enjoy reading?	☐	No	☐	Yes	_____
Is your child reading at grade level?	☐	No	☐	Yes	_____

How is your child's overall academic performance? ☐ Average ☐ Above average ☐ Below average

Does your child exhibit "behaviour problems" at school? _____

Is there any concern regarding learning disabilities? _____

What subjects/areas does your child enjoy/find easy? _____

What subjects/areas does your child find difficult? _____

Is your child working with any other professionals at school? (Speech pathologist, psychologist, learning facilitator, etc.)
Please list: _____

Are there any other concerns from school that you would like addressed? _____

Section III: Social History

Is your child outgoing or shy? ☐ Outgoing ☐ Shy ☐ Combination

Does your child handle change well?	☐	No	☐	Yes _____
Is your child easily frustrated?	☐	No	☐	Yes _____

How does your child respond when frustrated? _____

Please briefly describe your child's personality: _____

Are there any stresses in your child's life that we should be aware of? (Illness of family member, divorce, lost pet, etc)

Section IV: Vision Symptoms

Does your child ever complain of the following:

Blurred distance vision	☐	No	☐	Yes _____
Blurred near vision	☐	No	☐	Yes _____
Difficulty focusing on an object	☐	No	☐	Yes _____
Eyestrain (eyes feel sore/tired)	☐	No	☐	Yes _____
Headaches after visual tasks	☐	No	☐	Yes _____

Section V: Reading Symptoms

Have you ever noticed your child doing the following while reading:

Holding reading material "too close"?	☐	No	☐	Yes _____
Holding reading material farther away?	☐	No	☐	Yes _____
Closing/covering one eye?	☐	No	☐	Yes _____
Rubbing eyes?	☐	No	☐	Yes _____
Losing place/using a finger to follow?	☐	No	☐	Yes _____
Tilting head/distorting posture?	☐	No	☐	Yes _____
Skipping words or re-reading words?	☐	No	☐	Yes _____
Moving lips while reading silently?	☐	No	☐	Yes _____
Moving head?	☐	No	☐	Yes _____
Reversing words/letters?	☐	No	☐	Yes _____
Struggling to understand what was read?	☐	No	☐	Yes _____

Please feel free to include any other information that you feel would be beneficial in the care of your child, or any symptoms they are experienceing that are not included on this form.

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