Vision Park
FAMILY EYE CARE
www.vision-park.com
BETH TRIEBEL, OD • WENDY MULLER, OD • MELISSA BILLINGS, OD • TERI SHEPHERD, OD

Child's Full Name _____ Date _____
Last First M.I.

Parent's or Guardians' Names (Mother and Father) _____

Siblings (include ages) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business or Cell Phone: Father _____ Mother _____

Who will be responsible for this account? Name _____

❑ Check ❑ Cash ❑ VISA ❑ MasterCard ❑ Discover ❑ Insurance

Insurance Carrier _____ Policy # _____

Child's Age _____ Birthday _____ Grade _____

Last Visual Exam Date _____ Most Recent Eye Doctor _____ Were glasses prescribed? _____

When are they worn? _____ Age first prescribed _____ Vision Therapy or Eye Surgery _____

List ALL medications taken regularly _____

List ALL allergies to medications or the environment _____

How did you hear about us? ❑ Patient ❑ Doctor ❑ Therapist/Teacher ❑ Internet/Social Media

Name _____

PRESENT SITUATION

1. Describe any indications of visual or reading difficulty _____

_____

2. Does your child report any of the following?

	YES	NO	SOMETIMES	WHEN?	WHERE?
a. Headaches					
b. Blurred Vision					
c. Double Vision					
d. Eyes "hurt or tired"					
e. Eye turns In or Out					
f. One eye not as clear as the other					
g. Greater than 4 hours of screen use					

3. Has your child been diagnosed with Learning Disability _____ Developmental Delay _____ ADD/ADHD _____

Autism _____ Cerebral Palsy _____ Dyslexia _____

4. Do you and the teacher feel that the child is not working up to potential? _____

If you answered yes to any of the above – Please turn page and complete

SYMPTOM CHECKLIST

Name_____ Date_____

After each symptom listed, circle the number that best describes how often you experience that particular problem.

0= Never, 1 = Seldom, 2 = Occasionally, 3 = Frequently, 4 = Always

1.	Skips lines or loses place while reading or copying	0	1	2	3	4
2.	Omits small words	0	1	2	3	4
3.	Substitutes words while reading or copying	0	1	2	3	4
4.	Rereads words or lines in order to remember what was read	0	1	2	3	4
5.	Reverse letters (b & d, p & q), numbers or words	0	1	2	3	4
6.	Uses a finger or marker to keep place	0	1	2	3	4
7.	Reads very slowly	0	1	2	3	4
8.	Poor reading comprehension or it worsens over time	0	1	2	3	4
9.	Holds books close or leans in too close to papers and screens	0	1	2	3	4
10.	Squints, closes or covers one eye while reading	0	1	2	3	4
11.	Poor posture or tilts head when reading or writing	0	1	2	3	4
12.	Unusually tired, or falls asleep after completing a visual task	0	1	2	3	4
13.	Difficulty copying from board	0	1	2	3	4
14.	Crooked or poorly spaced writing	0	1	2	3	4
15.	Print moves or goes in and out of focus when reading	0	1	2	3	4
16.	Words overlap, run together or appear to jump when reading	0	1	2	3	4
17.	Misaligns letters or numbers especially in columns	0	1	2	3	4
18.	Clumsy, accident prone or poor coordination	0	1	2	3	4
19.	Poor, inconsistent performance in sports	0	1	2	3	4
20.	Loses concentration when doing close work, short attention span	0	1	2	3	4
21.	Avoids near tasks such as reading	0	1	2	3	4
22.	Confuses right and left directions	0	1	2	3	4
23.	Car sickness or motion sickness	0	1	2	3	4
24.	Burning, watery or red eyes	0	1	2	3	4
25.	Excessive blinking or eye rubbing	0	1	2	3	4
26.	Daydreaming	0	1	2	3	4
27.	Sensitivity to light	0	1	2	3	4
28.	Difficulty completing assignments in reasonable time	0	1	2	3	4
29.	Headaches or eyes hurt while watching "3D" movies	0	1	2	3	4
30.	Reading below grade level, finds reading a chore	0	1	2	3	4

SCHOOL HISTORY

Average School Work: ❑ Above Average ❑ Average ❑ Below Average

Best Subject _____ Hardest Subject _____ Age Started Kindergarten _____

Grades Repeated _____ Reason _____ Attitude Toward School _____

Describe any special tutoring, therapy, and/or remedial assistance (IEP, 504) including when, from whom, how long and results _____

_____

_____

_____

Describe any Problems Associated with School _____

_____

DEVELOPMENTAL HISTORY

Complications During Pregnancy _____ During/After Birth _____ Birth Weight _____

Complications of Development _____

Check any of the following which **DID NOT** occur at the expected time:

❑ Sit ❑ Crawl ❑ Stand ❑ Walk ❑ Put Puzzles Together

❑ Say First Words ❑ Talk in Sentences ❑ Ride Bicycle ❑ Begin Handwriting

Childhood Illnesses or Other Chronic Conditions (Age of diagnoses): _____

_____

_____

Accidents _____ Eye or Head Injuries _____

Family Doctor _____ Date of Last Physical _____ Describe Any Surgery _____

Other Conditions Which May Affect Development _____

_____

Has your child ever had a Neurological evaluation? _____ Date/Location _____

Psychological evaluation? _____ Date/Location _____

Hearing and/or Speech evaluation? _____ Date/Location _____

Occupational and/or Physical Therapy evaluation? _____ Date/Location _____

FAMILY HISTORY

(OTHER MEMBERS OF THE FAMILY)

Medical Problems (Diabetes, Blood Problems, Allergies, etc.)

Illness	Relationship	Age	Treatments and/or Complications

Visual Problems (Cataracts, Glaucoma, Amblyopia, Turning Eye, etc.)

Illness	Relationship	Age	Treatments and/or Complications

GIVE A BRIEF DESCRIPTION OF THIS CHILD AS A PERSON:

Thank You!