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Student History Form

GENERAL INFORMATION

Child's Full Name _____ Goes by: _____
Street Address: _____
City _____ State: _____ Zip: _____
Home phone # _____ Child's Age: _____
DOB _____

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

Mother's Occupation: _____
Cell phone: _____
Work phone: _____
Email: _____

Father's Occupation: _____
Cell phone: _____
Work phone: _____
Email: _____

School Name & Address: _____

Teachers Name: _____
Child's grade in school: _____

How did you hear about our center? _____
Who is your medical insurance carrier? _____

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 begin and 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 the child feel that he/she has a problem? _____
If yes, what is the child's attitude toward the problem? _____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, etc. That the child has experienced:

Illness/Injury	Age	Type of Severity	Complications (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any prescription or over-the-counter medication(s) being taken, dosage, name reason: _____

Health at present: **Excellent** **Good** **Fair** **Poor**

Does the child suffer from any chronic problems such as asthma, colds, allergies or ear infections? _____

When was your child's last eye exam? _____

Clinic name and address: _____

Were glasses recommended at any of their previous vision examination(s)? **Yes** **No**

Were treatment recommendations made? **Yes** **No**, If yes, explain: _____

Was the treatment program followed? **Yes** **No**

Was the treatment effective? **Yes** **No**

Has a vision therapy program ever been recommended? **Yes** **No**

o If yes has the program been completed? **Yes** **No**

Members of the family who have had vision treatment and why?

Name	Age	Visual Condition/Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any indications of hearing or speech-related problems? **Yes** **No**
If yes, explain: _____

DEVELOPMENTAL HISTORY

List any medications taken or complications during pregnancy:

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

Complications before, during or following delivery: _____

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

On hand and knees? Yes No At what age? _____

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

At what age did your child walk? _____

Did arm or legs require braces? Yes No

Which hand does your child use for Eating? _____ Writing? _____

Throwing? _____

Has he/she always used the same hand? Yes No

Was any guidance given? Yes No

Which foot doe he/she use for kicking? _____ Hopping? _____

Your child's first words were at age: _____

Was early speech clear to others? Yes No

Is it clear now? Yes No

GENERAL BEHAVIOR

Does he/she actively participate in play, sports, or athletics? Yes No

Which ones? _____

Does he/she enjoy music? Yes No

Can he/she carry a tune? Yes No

Can he/she keep rhythm? Yes No

Are there any behavior problems? Yes No

If yes, explain: _____

What causes these problems? _____

EDUCATIONAL HISTORY

Age at time of entrance to: Kindergarten: _____

First grade: _____

Does your child like school? _____

Does your child like the teacher? _____

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

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

Specifically describe any school difficulties: _____

What subjects are easy for your child? _____

Possible reasons for difficulties? _____

Has a grade been repeated? _____ If yes which grade? _____

Does your child attend any special need classes? Yes No

If yes, explain: _____

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

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

If yes, what? _____

Does your child read on his/her own? Yes No

Does your child prefer to be read to? Yes No

What is your child's present reading level (by grade level definition)? _____

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

Please list any psychological or educational tests performed: _____

HOME ENVIRONMENT

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

Name	Age	Gender	Relationship to the child
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Additional home information we should know (frequent moving, separation, divorce, remarriage, death, etc.) _____

Previous nursery or other group experiences (Sunday school, camp, daycare, etc.):

INTERESTS AND HOBBIES

Does he/she have any special abilities (art, music, etc.)? _____

Favorite activities-what does you child find most rewarding? _____

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

RELEASE

The doctor in our clinic specializes in the diagnosis and treatment of functional vision problems. Our clinic does visual efficiency and visual information processing evaluations.

The doctor in our clinic does not perform primary-care eye health exams. We do recommend that you have an eye health exam yearly by a primary-care optometrist. If we require you to have this exam prior to your visit with our doctor we will let you know. If you would like a list of primary care optometrists please let us know.

I understand that the doctor will not be assessing my child's eye health in the course of his/her evaluation. I further understand that it is recommended that I have an eye health examination yearly by a primary-care optometrist. I agree to allow Vision Therapy KC to send the records from my exam to my primary care optometrist. If you have not had a primary eye health exam the previous statement is not applicable.

Signed (patient or parent if patient under 18)

Dated

DISCLAIMER (Our lawyer made us do it.)

The developmental vision evaluation and report consultation are completed at no charge. No strings attached. We are committed to providing quality developmental vision testing so patients and their families can learn about their possible vision needs, beyond a routine 20/20 eye exam. Providing the testing free of charge removes a significant barrier to those seeking information about this unique and valuable area of vision care.

A summary of the testing, along with diagnosis information and recommendations from the doctor are provided during the consultation for you, the referring doctor and other professionals. We are also glad to provide letters of predetermination for insurance and copies of reports for referring doctors or other professionals.

If records or reports, beyond what is provided during the consultation, are requested by non-returning patients or for use outside of our office, this requires us to charge for both the evaluation and expanded report at our customary fee of \$600.