Vision Sense
68 Lovett Lake Crt.
Halifax, N.S B3S 1B8
www.Vision-Sense.ca
902.454.1520

CHILD INTAKE FORM (BV)

Full Name: **Preferred Name:**

Date of Birth: **Age:** **Gender:** X **Handedness:**

Address:

Parent/Guardian Information

Name: Telephone: Mobile:

Address:

Occupation/Employer: Work Phone:

Email Address:

Parent/Guardian Information

Name: Telephone: Mobile:

Address:

Occupation/Employer:

Email Address:

Siblings (age and gender):

Name of School: **Grade:**

Teacher(s): **Telephone:**

Referred by: **Profession:**

Telephone: Reason for Referral:

What would you like to find out from the exam:

Family Doctor: **Telephone:**

Last Checkup: **Any known conditions:**

Current Medications:

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Other practitioners or services that your child sees/uses:

Name	Profession	Telephone

PRESENT SITUATION AND VISUAL HISTORY:

In what ways does your child seem to struggle? How does your child complain about their vision?

How long has difficulty been noticed?

Has anyone noticed an eye turn in or wander out? No When?

Previous visual examinations:

Reason for examination	Doctor's Name	Date	Result

Do you have any family members who have required visual attention?

Relation to child	Age	Visual Situation

Does your child ever report any of the following, and if yes, when?

- ☐ Headaches
- ☐ Eyes sore or tired
- ☐ Blurred vision at Far
- ☐ Double Vision
- ☐ Blurred at Near
- ☐ Light sensitivity

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Have you ever noticed the following?	**When?**
☐ Holding reading close?	
☐ Distorted posture when reading?	
☐ Holding reading further away?	
☐ Inability to see distance objects?	
☐ Closing one eye?	
☐ Bumping into objects?	
☐ Covering one eye?	
☐ Poor general coordination?	
☐ Eyes frequently reddened?	
☐ Skips words or rereads?	
☐ Frequent sties?	
☐ Reverses words/letters?	
☐ Excessive eye rubbing?	
☐ Moves lips while reading quietly?	
☐ Get lost when reading?	
☐ Moves head while reading?	
☐ Uses finger to follow words?	
☐ Tilts head while reading?	

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DEVELOPMENTAL HISTORY

Is your child adopted? No If yes, does the child know? Age when adopted?

Full term pregnancy? No **Any complications before, during, or following delivery?** No

Was the child exposed in utero to: ☐ drugs ☐ alcohol ☐ nicotine ☐ OTHER

At what age did your child crawl? **At what age did your child walk?**

At what age was their first word? **At what age was their first sentence?**

Does your child have a speech or language deficit? No

If yes, has any attempt been made to correct it? No

Was therapy successful? No

When fatigued, child will: ☐ Sag ☐ Become irritable ☐ Become excited ☐ Other

Under tension, is there any pattern of behavior, thumb-sucking, etc.?

Is there any other information you would like us to know about your child's development?

SCHOOL

Age at time of entrance?

Does your child like school? Sometimes **Was a grade repeated?** No

Is performance in school: Average

Have there been any school difficulties?

What subjects are considered easiest? **Most difficult?**

Does test taking appear to cause anxiety? No

Does your child have a diagnosed learning difficulty?

Does the school consider your child to have an undiagnosed learning difficulty?

Does the school consider your child to have behavioural difficulties?

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Does your child enjoy reading? No **Do they read at an age appropriate level?** No

SOCIAL

Does your child have close friends? No

What are your child's favorite things to do?

Is your child a picky eater? No **Does your child's appetite fluctuate frequently?** No

What are your child's favorite foods?

When is your child's bedtime? **How many hours of sleep per night (on average)?**

Does your child fall right to sleep, or does it take them a while?

Do they sleep through the night? No **If no, how many times are they up?** Why?

Is there anything else we should know about your child?

As you completed this history questionnaire, you likely recognized the thoroughness with which the conditions of your child's life will be considered.

The office examination will take up enough time to permit a very complete optometric investigation of the issues outlined. It is desirable to have **both parents** present during the examination.
Your child's future deserves the fullest consideration that you as parents, and we here in the office, can provide.

In order for us to keep costs down, payment is expected in full at the time of service.

I authorize the release of medical and/or other information pertinent to my child's care to the insurance company in order for me to be reimbursed.

Signature: **Date:**