Pediatric/Specialty Intake Form

Name:	DOB:

Do you or your child experience any of the symptoms below?

Refractive
- ☐ Complains of blurred vision
- ☐ Rubs eyes frequently
- ☐ Squints

Vergence
- ☐ Closes or covers one eye
- ☐ Occasionally sees double
- ☐ Rubs eyes frequently
- ☐ Able to read for only a short time
- ☐ Poor reading comprehension

Accommodative
- ☐ Holds things very close
- ☐ Complains of blurred vision
- ☐ Poor reading comprehension
- ☐ Says eyes are tired
- ☐ Able to read for only a short time
- ☐ Has headaches when reading

Occulomotor
- ☐ Moves head excessively when reading
- ☐ Frequently loses place, skips lines when reading
- ☐ Uses finger to keep place
- ☐ Poor reading comprehension
- ☐ Short attention span

Visual Form Perception
- ☐ Mistakes words with similar beginnings
- ☐ Difficulty recognizing letters, words, or simple shapes and forms
- ☐ Can't distinguish the main idea from insignificant details
- ☐ Trouble learning basic math concepts of size, magnitude, and position

Visual Memory
- ☐ Trouble visualizing what is read- Poor reading comprehension
- ☐ Poor speller
- ☐ Trouble with mathematical concepts
- ☐ Poor recall of visually presented material

Visual-motor Integration
- ☐ Sloppy handwriting and drawing
- ☐ Can't stay on lines
- ☐ Poor copying skills
- ☐ Can respond orally but not in writing

Laterality and Directionality
- ☐ Trouble learning right and left
- ☐ Reverses letters and words
- ☐ Trouble writing and remembering letters and numbers

Pre/Post Natal
Birth weght _____

APGAR score _____

Delivery method _____

Complications ☐ Gestation ☐ Delivery ☐ None

Describe _____

Full-term ☐ yes ☒ no

Oxygen ☐ yes ☒ no

Substance use ☐ yes ☒ no

If yes _____

Development
Crawling _____ months

First speech _____ months

Walking _____ months

Educational
School _____

Grade _____

Teacher _____

Reading level _____

Therapies
OT ☐ yes ☒ no

Speech ☐ yes ☒ no

ABA ☐ yes ☒ no

Additional Comments: