PEDIATRIC INFORMATION FORM

Patient's Name: ________________________________ **DOB:** ________________________________

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

REFRACTIVE	**YES**	**NO**	**PRE/POST NATAL**
Complains of blurred vision			Birth Weight ________________ APGAR score ________________ Delivery method ________________
Rubs eyes frequently			
Squints			
			Complications:
VERGENCE			Gestation
Closes or covers one eye			Delivery
Occasionally sees double			None
Rubs eyes frequently			YES / NO
Able to read for only a short time		Full-term	
Poor reading comprehension		Oxygen	
		Substance Use	
ACCOMMODATIVE			If yes:
Holds things very close			
Says eyes are tired			
Has headaches when reading			**EDUCATIONAL**

			School ____________________
			Grade ____________________
			Teacher ____________________
			Reading level ____________________

OCCULOMOTOR					
Moves head excessively when reading					
Frequently loses place, skips lines					
Uses finger to keep place					
Short attention span					
			THERAPIES	**YES**	**NO**
VISUAL FORM PRECEPTION			OT		
Mistakes words with similar beginnings			Speech		
Difficulty recognizing letters, words, or simple shapes and forms.			ABA		
Can't distinguish the main idea from insignificant details					
Trouble learning basic math concepts, of size, magnitude and position.					

VISUAL MEMORY	**YES**	**NO**	**ADDITIONAL COMMENTS:**
Trouble visualizing what is read – poor 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		