



LEARNING RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ Male Female Other _____
Date of Birth: _____ (M/D/Y) Age: _____ Home Phone: _____
Address: _____
City: _____ Postal Code: _____
Parent's Names _____ & _____
Parent's Cell Number _____ & _____
Email: _____ Referred by: _____
Health Card #: _____ VC _____
Last Eye Exam: _____ Optometrist: _____
Optometrist's Phone Number: _____ Fax Number: _____
Grade: _____ School: _____
Individualized Education Program: Yes No

HEALTH HISTORY

Family Doctor: _____
Family Doctor's Phone Number: _____ Fax Number: _____
Please list any current medical conditions: _____
Past surgical history: _____
Medications: _____
Allergies: _____
Is your child generally healthy? Yes No
Is there a history of bad fall(s) that resulted in a head injury? Yes No
If Yes, was it considered Mild, Moderate or Severe: _____
Is there a history of high fevers? Yes No
If Yes, was it considered Mild, Moderate or Severe: _____
What was the frequency of the fevers? _____
Is there a history of chronic ear infections? Yes No
If Yes, was it considered Mild, Moderate or Severe: _____
Did your child have tubes put in? Yes No
Did your child have surgery to treat the ear infections? Yes No

DEVELOPMENTAL HISTORY

Did mother experience any health problems during the pregnancy? Yes No

If YES, please explain: _____

Were there any complications with the birth? Yes No

If YES, please explain: _____

Was the child born premature? Yes No

If yes, what was the length of pregnancy? _____

Did your child crawl? Yes No

What type of crawl did your child do?

Stomach on floor On all fours Bum scooted

At what age did your child walk? _____

Were there any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, skipped crawling, toe walking etc.)? Yes No

If yes, please explain: _____

Any current or past speech problems: Yes No

What age did your child say their first word? _____

Was early speech clear to others? _____

Is speech clear now? Yes No

Receiving any special development assistance? OT PT Speech Other _____

If ADD/ADHD or a Learning Disability or Dyslexia was diagnosed, who diagnosed it, how was it diagnosed and when?

SCREEN TIME

Does your child watch television? Yes No

How many hours a week does your child watch television? _____

Does your child play video games? Yes No

How many hours a week does your child play video games? _____

Does your child use a smartphone/tablet? Yes No

How many hours a week does your child spend on the smartphone/ tablet? _____

How is your child likely to use the smartphone/tablet? (Please circle all that apply)

Play games Watch videos Social media Other

Please list all extra-curricular activities your child is currently engaged in (sports, swimming, music, gymnastics, dance etc.)

Hours per week: _____

Hours per week: _____

Hours per week: _____

OBSERVATIONS

Physical Signs / Complaints

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Headaches, especially after near work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exhausted after day of school	<input type="checkbox"/>	<input type="checkbox"/>	_____
Car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurry vision, even with glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequently rubs eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to side when watching TV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts or turns head during deskwork	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closes/covers an eye during deskwork	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head gets close to reading material	<input type="checkbox"/>	<input type="checkbox"/>	_____

Reading

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Words run together, move, or double when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, repeats lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger to maintain place	<input type="checkbox"/>	<input type="checkbox"/>	_____
Omits words when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slow reader compared to peers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty reading words (decoding)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires rapidly and loses attention when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes chapter books	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads well for short time, then slows	<input type="checkbox"/>	<input type="checkbox"/>	_____

Writing / Drawing

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Difficulty copying from board	<input type="checkbox"/>	<input type="checkbox"/>	_____
Copying takes longer than normal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Copies words backwards	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses numbers, letters, or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes up/ down hill	<input type="checkbox"/>	<input type="checkbox"/>	_____
Misaligns digits/columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	_____

Mathematics

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Difficulty learning to count	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor memory for numbers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with math problem-solving skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty reading clocks with hands	<input type="checkbox"/>	<input type="checkbox"/>	_____

Attention

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Attention better when listening rather than reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constantly fidgets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Homework is a battle; can't concentrate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor eye contact; appears to not be listening	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can't locate belongings/ things or forgets	<input type="checkbox"/>	<input type="checkbox"/>	_____

Behaviour

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Does not socialize well with other children	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not like going to school	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficult to discipline at home	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxious frequently	<input type="checkbox"/>	<input type="checkbox"/>	_____
New situations/events (transitions) difficult	<input type="checkbox"/>	<input type="checkbox"/>	_____
Under fatigue/stress, child withdraws	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequently says "I can't" before trying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feels "stupid," poor confidence	<input type="checkbox"/>	<input type="checkbox"/>	_____

Coordination

	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Clumsy, poor balance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Falls frequently or trips	<input type="checkbox"/>	<input type="checkbox"/>	_____
Often knocks things over, esp. at table (messy eater)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties learning bike riding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can't keep eye on ball, or hit a ball (catching, batting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads a lot, avoids exercise	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with puzzles	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY & HOME

Please indicate who your child lives with: (Please circle all that apply)

- Mother Father Siblings Stepmother Stepfather
 Adoptive Parents Grandmother Grandfather Aunt Uncle
 Foster Parents Other caretaker (please specify): _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes No Reason: _____

If YES, at what age did it occur? _____

Did the father or anyone in the father's family have a learning problem? Yes No

If YES, who? _____

Did the mother, or anyone in the mother's family have a learning problem? Yes No

If YES, who? _____

Do any, or did any, of the other children in the family have a learning problem? Yes No

If YES, Who? _____

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Signature

Date