Welcome to Our Practice

FreSh VISION OPTOMETRISTS

Personal Details

Child's Full Name_____
Child's Preferred Name_____ Male [ ] Female [ ]
Parent/Guardian Name_____ Male [ ] Female [ ]
Address_____ Postcode_____
Parent/Guardian Email_____ Child's Date of Birth / /
Parent/Guardian Mobile_____
Child's Medicare Number_____ Ref Number____Expiry Date / /
Is your child covered by Private Health Insurance? Yes [ ] No [ ]
Private Health Fund Provider_____
GP's Name_____ GP's Phone_____
GP's Address_____ Postcode_____
What is the main reason for your visit today?

_____
_____

Medical History

Has your child previously been assessed by any of the following?

Educational Psychologist [ ] Audiologist [ ] Speech Pathologist [ ]
Occupational Therapist [ ] Ophthalmologist [ ] Paediatrician [ ]

Has your child been diagnosed with any behavioural or learning difficulties? Yes [ ] No [ ]
If yes, please specify:_____
Does your child currently wear glasses? Yes [ ] No [ ]
Does your child have other health conditions we should be aware of?

_____
Please list any medications your child is currently taking:_____
_____

Education

Name of School_____
Year level_____
Is your child having difficulty with any of the following?
Reading [ ] Spelling [ ] Writing [ ] Maths [ ] Behaviour [ ]
Has your child repeated a grade? Yes [ ] No [ ]

Birth and Development - please complete this section if your child is aged under 7

Did you experience any complications during birth? Yes [ ] No [ ]
If yes, please specify:_____
At what age did your child start to crawl?_____
At what age did your child start to talk?_____
Is your child right handed or left handed? Left [ ] Right [ ]

Eye Teaming Ability

Does your child:

Complain of eye strain ..... Yes [ ] No [ ]
Complain of headaches ..... Yes [ ] No [ ]
Complain of moving words on the page ..... Yes [ ] No [ ]
Cover or close one eye when reading ..... Yes [ ] No [ ]
Have an eye that turns inward or outward constantly when tired .. Yes [ ] No [ ]
Lose place when reading ..... Yes [ ] No [ ]
Have poor reading comprehension .. Yes [ ] No [ ]

Focusing Ability

Does your child:

Complain of blurred vision when reading ..... Yes [ ] No [ ]
Hold a book very close ..... Yes [ ] No [ ]

Tracking Ability

Does your child:

Lose place on a page often ..... Yes [ ] No [ ]
Skip words and lines often ..... Yes [ ] No [ ]

How did you hear about us?

Relative / Friend / Previous Patient .. Yes [ ]
Your GP ..... Yes [ ]
Internet Search / Our Website ..... Yes [ ]
Facebook / Social Media ..... Yes [ ]
Print Advert ..... Yes [ ]
Other _____

Future Communication

Are you happy to receive occasional communications including appointment reminders, eye health information and special offers by mail, email and sms? ..... Yes [ ] No [ ]

Signature _____ Date / /

Thank you for entrusting us with your eyecare

Privacy Statement: Our practice respects your privacy and will comply with the Privacy Act and the Australian Privacy Principles when handling your personal information (including health information). We use your personal information to help us provide services to you. We may also use your personal contact information to send you information regarding eye health, eye care and eyewear, with your consent. By providing the information requested in the first three sections of this form we will be able to make an informed decision on how to best meet your eye care and eyewear needs. We may also need to provide some personal information to third party suppliers (such as providers of mail-out and electronic distribution services and eyewear suppliers) if and to the extent necessary for them to provide the relevant goods or services (for example prescription eyewear or contact lenses). You can access all the personal information that we hold about you. Please contact us if you would like to know more about how we handle personal information or to see or obtain a copy of our full privacy policy.