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BEYOND TRADITIONAL VISION CARE

IMPORTANT: *The information on this intake form will enable the doctor to ascertain and evaluate your child's needs most effectively. Please fill out the following as completely as possible and* ***PLAN 2 HOURS*** *for the initial examination. We look forward to meeting you!*

INSTRUCTIONS: *1) Using your computer, you may type directly on this form.* ***PRINT A HARD COPY*** *in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form and write the information directly in the spaces provided. Fax or mail the completed form to the fax number or address in the upper right-hand corner. PLEASE forward any other pertinent records to our office after this form has been submitted.*

I. Child's Information

Last name ____________ First ____________ Middle ____________ Called by ____________

Birth date Month ______ Day ______ Year ______ Age Years ______ Months ______ ❑ Male ❑ Female

Street address ________________________________

City ____________ State ______ Zip ______ E-mail ____________

Home phone (   ) ________________________________

Mom's mobile phone (   ) ____________ Dad's mobile phone (   ) ____________

Favorite activity / position ____________ Least favorite activity / position ____________

____

Who referred you to us? ________________________________

II. Present Situation

Reason for evaluation:
Type Here:

Who first noticed the child's problem and when?
Type Here:

Did the problem occur suddenly?
Type Here:

Do the child's problems seem to be related to illness, accident, or other trauma?
Type Here:

Have you noticed any differences in this child compared to siblings or other children?
Type Here:

Ordinal position of child (i.e. 3rd of 6 = 3/6) ______

Siblings:	**Name:**	**Age**	**Adopted**		**Difficulty in school**	
			Yes	**No**	**Yes**	**No**
	______		❑	❑	❑	❑
	______		❑	❑	❑	❑
	______		❑	❑	❑	❑

Number of household moves in child's lifetime? ______

Does child like to be read to? ❑ yes ❑ No

Motor Control:

Which hand does your child prefer to use for eating? ❑ Left ❑ Right Always? ❑ Yes ❑ No

Does child have an awkward gait? ❑ yes ❑ No

Is your child exceptionally clumsy? ❑ yes ❑ No

Describe body position at sleep. ______

______

Foods: Please list foods your child likes and foods that are avoided or disliked.

Likes
Type here:

Dislikes
Type here:

Sleeping / Activity:	**Never**	**Sometimes**	**Often**
Restless while awake	❑	❑	❑
Requires frequent naps	❑	❑	❑
Restless during sleep	❑	❑	❑
Difficulty getting to sleep	❑	❑	❑
Does not get enough sleep	❑	❑	❑
Needs large amount of sleep	❑	❑	❑
Extreme fatigue	❑	❑	❑
Awakens tired and slow	❑	❑	❑
Irregular arising time	❑	❑	❑

Eating:	**Never**	**Sometimes**	**Often**
Finicky eater	❑	❑	❑
Irregular elimination habits	❑	❑	❑
Eats large amount of sweets	❑	❑	❑
Eats rapidly	❑	❑	❑
Sensitive stomach	❑	❑	❑
Bites nails	❑	❑	❑
Food Allergies	❑	❑	❑

What are they? ______

III. Pregnancy and Delivery History

During Pregnancy

	Yes	No
Was child active in utero?	❑	❑
Blood incompatibility (RH)	❑	❑
Hemorrhage	❑	❑
Usage of internal medications during pregnancy	❑	❑
Barbiturates?	❑	❑
Hallucinogenic?	❑	❑
Excessive alcohol?	❑	❑
Labor - spontaneous with no complications?	❑	❑

If no, please explain

Type Here:

	Yes	No
Adequate and regular nutrition during pregnancy?	❑	❑
Toxemia (blood poisoning)	❑	❑
Major illness or trauma	❑	❑
Pelvic x-rays	❑	❑
Other abnormalities	❑	❑
If yes, what? ____________________		
Excessive smoking?	❑	❑

Type of delivery: Baby position at birth:

Labor and Delivery:

Length of Pregnancy Birth Weight lbs. oz. Length in.

After Birth:

	Yes	No
Blood exchange transfusion	❑	❑
Anoxia (lack of oxygen)	❑	❑
Incubator	❑	❑
Poor sucking	❑	❑
Cord around neck	❑	❑

	Yes	No
Severe jaundice	❑	❑
Resuscitation	❑	❑
Seizures	❑	❑
Abnormal cry	❑	❑

Others, Specify:____________________

IV. Child's Early Medical History

Past Illnesses:	Yes	No	Age
Head trauma	❑	❑	_______
Convulsions or seizures	❑	❑	_______
Diabetic	❑	❑	_______
Encephalitis	❑	❑	_______
Rheumatic fever	❑	❑	_______
Asthma	❑	❑	_______
Measles (severe)	❑	❑	_______
High fever	❑	❑	_______

	Yes	No	Age
Serious infections or injury	❑	❑	_______
Reactions to drugs, vaccine allergies	❑	❑	_______
Allergies - what? _______________	❑	❑	_______
Severe ear infections	❑	❑	_______
Hospitalization - If yes, for what? ____________________	❑	❑	_______
Frequent respiratory infections	❑	❑	_______
Other ____________________	❑	❑	_______

Is child receiving any medication at this time? if yes, for what purpose?
Type here:

V. Developmental History

Information obtained from: Baby book ❑ Other records ❑ Memory ❑

	Norm	Early	Average	Slow	Comments:
Teething:					
2 lower central incisors	6-9 Mo.	❑	❑	❑	Type here:
4 upper lateral incisors	8-12 Mo.	❑	❑	❑	
4 Posterior Molars	24-30 Mo.	❑	❑	❑	
First permanent teeth	5-6 Yrs.	❑	❑	❑	
Gross Motor:					
Were there any problems in neck control development?	4 mo.	❑	❑	❑	Type here:
Sitting alone	8 Mo.	❑	❑	❑	
Crawling alone	9 Mo.	❑	❑	❑	
Unusual crawl pattern (describe) ___					
Stand alone	15 Mo.	❑	❑	❑	Type here:
Walk alone	15 Mo.	❑	❑	❑	

Speech - Auditory History

		Norm	Early	Average	Slow	Comments:
Speech:	Syllables	6 Mo.	❑	❑	❑	Type here:
	Da-da, etc.	9 Mo.	❑	❑	❑	
	2 words	12 Mo.	❑	❑	❑	
	4 words	15 Mo.	❑	❑	❑	
	Short Sentences	24 Mo.	❑	❑	❑	
	Gives Full Name	30 Mo.	❑	❑	❑	

Does child reply appropriately to simple directions and questions? ❑ Yes ❑ No

Does child have to look at you to understand what you say? ❑ Yes ❑ No

Bilingual Parent ❑ Yes ❑ No

What Other Language(s) are Spoken at Home? ___

Visual History

Does child have glasses now? ❑ Yes ❑ No Does child wear them? ❑ Yes ❑ No

If yes, when should child wear them? ___

Have child's lenses been changed? ❑ Yes ❑ No How often?

Visual History Continued

Have you noticed the child:	Yes	Sometimes	No
avoiding bright lights	❑	❑	❑
rubbing eyes frequently	❑	❑	❑
developing sties	❑	❑	❑
blinking excessively	❑	❑	❑
having red eyes	❑	❑	❑
sitting too close to the TV	❑	❑	❑
other ____________________	❑	❑	❑

When and how often do these symptoms occur?
Type here:

VI. Previous Evaluations (Please fill in all that apply)

Vision - For what reason? ____________________

By Whom ____________________ Date __________

Address ____________________

Speech-Hearing - For what reason? ____________________

By Whom ____________________ Date __________

Address ____________________

Neurological - For what reason? ____________________

By Whom ____________________ Date __________

Address ____________________

Other - For what reason? ____________________

By Whom ____________________ Date __________

Address ____________________

Please request copies of all previous evaluation reports be sent to us prior to evaluation date to complete our history of your child.

VII. Family Medical History

Family history to three generations: If yes, please specify relationship:

	Yes	No	Relationship		Yes	No	Relationship
Multiple births	❑	❑	__________	Bilingual parent	❑	❑	__________
Hereditary diseases	❑	❑	__________	Visual problems	❑	❑	__________
Neuropsychiatric disorders	❑	❑	__________	Auditory problems	❑	❑	__________
Left handedness	❑	❑	__________	Diabetic	❑	❑	__________
Speech difficulty	❑	❑	__________	Epileptic	❑	❑	__________
Reading and writing difficulty	❑	❑	__________	Asthmatic	❑	❑	__________
Hyperactivity	❑	❑	__________	Allergies	❑	❑	__________

VIII. Parent or Guardian Information

Father's [or guardian] name

Street address [if different from child's]

City State Zip

Home phone Work phone

E-mail

Mother's [guardian] name

Street address [if different from child's]

City State Zip

Home phone Work phone

E-mail

Signature Date

We will ask you to sign this form at your first visit.

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A small photo is useful for our files. Please bring one with you to the examination OR insert a digital image. For successful e-mailing capacity It must be 150K or less @ 72dpi.

INSERT IMAGE HERE

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