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Developmental, Rehabilitative & General Optometry

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CHILD/YOUTH INFORMATION

Last name:________________________________First Name:____(M / F)

Date of Birth (mm/dd/yy):______________________Health Card #:______________________________VC:___Home

Address:____Apt/Unit#: ______________

City:________________________Postal Code:___________________Home Phone:______________________________

Cell Phone:__________________________Email Address: ____

How did you hear about us? ____

When was your last eye exam?____________________Who was the eye doctor? _______________________________

Medical History…..

- ☐ Autism/ASD/Aspersers
- ☐ ADD/ADHD
- ☐ Developmental Delay
- ☐ Premature
- ☐ Tubes in ears
- ☐ Broken bones
- ☐ Diabetes
- ☐ Asthma
- ☐ Other____________________________________
- ☐ List Medication______________________________
  ____
- ☐ List Allergies______________________________
  ____

Family Eye / Family Medical Problems

____
____
____

Eye History…..

- ☐ Cataracts
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Colour blindness
- ☐ Turned or wandering eye
- ☐ Eye surgery
- ☐ Dry eye
- ☐ Lazy eye
- ☐ Vision therapy
- ☐ Eye injury

Current Appearance or behaviours...

- ☐ Red eyes
- ☐ Watering eyes
- ☐ Discharge from eye
- ☐ Rubs eyes
- ☐ Sensitive to light
- ☐ Poor concentration/ easily distracted
- ☐ Angry
- ☐ Depressed
- ☐ Happy

Current Symptoms…..

- ☐ Trouble seeing distance
- ☐ Trouble reading
- ☐ Blur
- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Tired eyes
- ☐ Burning eyes
- ☐ Double vision
- ☐ Flashes
- ☐ Spots
- ☐ Achy eyes
- ☐ Nausea
- ☐ Dizziness

Uses…..

- ☐ Eye drops
- ☐ Eye Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Hot compresses
- ☐ Eye patch

Educational History

Current School / grade: ____________________________

Is your child receiving any tutoring, extra help or special classes? ☐ Yes ☐ No

Does your child have an IEP? ☐ Yes ☐ No

Reading

☐ Above Grade ☐ On Grade ☐ Below Grade

- ☐ Loss of place
- ☐ Words move or running together
- ☐ Poor reading comprehension
- ☐ Word reversals
- ☐ Avoids reading
- ☐ Poor, inefficient reading
- ☐ Holds book close
- ☐ Head aches
- ☐ Other______________________________________

Printing/Writing/Spelling

☐ Above Grade ☐ On Grade ☐ Below Grade

- ☐ Letter reversals
- ☐ Difficulty copying from board
- ☐ Poor Printing
- ☐ Poor cursive writing
- ☐ Poor spelling
- ☐ Other______________________________________

Math

☐ Above Grade ☐ On Grade ☐ Below Grade

- ☐ Difficulty with word problems
- ☐ Misaligns numbers
- ☐ Difficulty with addition
- ☐ Difficulty with fractions
- ☐ Difficulty with multiplication
- ☐ Difficulty with geometry
- ☐ Other______________________________________

Gym/Sports/Coordination

☐ Above Grade ☐ On Grade ☐ Below Grade

- ☐ Eye-hand difficulty (kicking, throwing, catching)
- ☐ Difficulty with fine motor control (manipulation with hands/fingers)
- ☐ Difficulty with gross motor control (running, hopping)
- ☐ Skipping and rhythm
- ☐ Balance problems
- ☐ Other______________________________________

Developmental History

Were there any complications with pregnancy or during birth? ☐ Yes ☐ No

If yes, please describe______________________________

____

____

Was your child born prematurely? ☐ Yes ☐ No

If yes, how soon?______________________________

Child's birth weight: ______________________________

When did your child begin walking unassisted? ________

When did your child begin toilet training?____________

When did your child begin to say 2-3 word phrases?

____

Any speech problems now or in the past ☐ Yes ☐ No

Does/did your child enjoy and participate in activities such as drawing, colouring, puzzles, block play, etc.?

☐ Yes

☐ No

At Home Habits

- ☐ Has a messy room
- ☐ Has trouble tying their shoes
- ☐ Is typically a messy eater
- ☐ Has difficulty using forks and knives
- ☐ Often forgetful
- ☐ Often clumsy
- ☐ Difficulty following verbal directions

Other Necessary Information ____

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