visualsense EYECARE
Optometry & Vision Therapy

OFFICE USE ONLY:
RET PHOTO TAKEN [ ]
TAKE RET PHOTO WHEN DILATED [ ]
NO RETINAL PHOTO [ ]
SCANNED [ ]

EXAMINATION INTAKE FORM – CHILD

PLEASE PRINT CLEARLY

CHILD'S FULL NAME:	BIRTH DATE (DD/MM/YY):	MALE [ ] FEMALE [ ]
HOME ADDRESS:	HEALTH CARD #:	
CITY:	PARENT'S NAMES:	
POSTAL CODE:	CELL PHONE #:	
HOME PHONE #:	ALTERNATE #:	
EMAIL ADDRESS:		
[ ] I GIVE VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS **[ ]I DO NOT GIVE** VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS		
SIGNATURE OF CONSENT:	DATE OF CONSENT:	

COVID-19 HEALTH HISTORY in the past 14 days:

Do you have fever, new onset of cough, worsening chronic dough, shortness of breath, or difficulty breathing?
[ ] Yes **[ ]** No

Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19?
[ ] Yes **[ ]** No

Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada?
[ ] Yes **[ ]** No

Have you travelled recently?
[ ] Yes **[ ]** No

Do you have pink eye (conjunctivitis)?
[ ] Yes **[ ]** No

HOW WERE YOU REFERRED TO US?	REASON FOR REFERRAL:

HEALTH HISTORY

FAMILY DOCTOR:	DATE OF LAST EYE EXAM:
ALLERGIES (please specify):	HOSPITALIZATIONS:
MEDICATIONS:	REASONS FOR MEDICATIONS:

ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, **PLEASE INDICATE WHO [grandmother, father, etc])**

[ ] SELF [ ] FAMILY ENVIRONMENTAL ALLERGIES	**[ ] SELF [ ] FAMILY** HIGH BLOOD PRESSURE
[ ] SELF [ ] FAMILY HEART DISEASE	**[ ] SELF [ ] FAMILY** CATARACTS
[ ] SELF [ ] FAMILY ARTHRITIS	**[ ] SELF [ ] FAMILY** GLAUCOMA
[ ] SELF [ ] FAMILY HIGH CHOLESTEROL	**[ ] SELF [ ] FAMILY** STROKE
[ ] SELF [ ] FAMILY MACULAR DEGENERATION	**[ ] SELF [ ] FAMILY** RETINAL DETACHMENT
[ ] SELF [ ] FAMILY EYE INJURY	**[ ] SELF [ ] FAMILY** TUBERCULOSIS
[ ] SELF [ ] FAMILY DIABETES	**[ ] SELF [ ] FAMILY** HIV/ HEPATITIS
[ ] SELF [ ] FAMILY EYE SURGERY	**[ ] SELF [ ] FAMILY** NEUROMUSCULAR

VISUAL HISTORY & EYE HEALTH

[ ] BLURRED DISTANCE VISION / SQUINTING	**[ ]** UNCOMFORTABLE CONTACT LENSES
[ ] BLURRED INTERMEDIATE VISION	**[ ]** AMBLYOPIA (LAZY EYE)
[ ] BLURRED CLOSE VISION	**[ ]** DROOPING EYELID
[ ] SUDDEN VISION LOSS	**[ ]** FLUCTUATING VISION
[ ] DOUBLE VISION	**[ ]** GLARE/ LIGHT SENSITIVITY
[ ] FLOATING SPOTS	**[ ]** MUCUS DISCHARGE
[ ] RED EYES	**[ ]** STRABISMUS
[ ] WATERY EYES/ BURNING EYES	**[ ]** CORNEAL TRANSPLANT
[ ] FREQUENT HEADACHES	**[ ]** EYE TURN
[ ] FLASHES OF LIGHT	**[ ]** KERATOCONUS
[ ] DRY EYES	**[ ]** OTHER:
HISTORY OF CONCUSSION: **[ ] YES [ ] NO**	DATE OF LAST CONCUSSION (MM/DD/YY):
PARTICIPANT OF COMPETITIVE SPORT : **[ ] YES [ ] NO**	

VISUAL HISTORY

Any learning-related diagnosis? **[ ] YES [ ] NO** IF SO, PLEASE LIST:

Please describe any previous eye or visual problems and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc…):

EDUCATIONAL HISTORY

CURRENT SCHOOL:	GRADE:
HAS YOUR CHILD REPEATED ANY GRADES? **[ ] YES [ ] NO** IF YES, WHICH ONES?	
IS YOUR CHILD RECEIVING ANY TUTORING, EXTRA HELP OR SPECIAL CLASSES? **[ ] YES [ ] NO** IF YES, PLEASE DESCRIBE:	

ACADEMIC COMPLAINTS

[ ] LOSS OF PLACE WHILE READING/ SKIPPING WORDS & LINES	**[ ]** WORDS MOVING OR RUNNING TOGETHER
[ ] POOR HANDWRITING	**[ ]** DIFFICULTY COPYING FROM THE BOARD
[ ] HOLDS BOOK TOO CLOSE	**[ ]** POOR READING COMPREHENSION
[ ] POOR SPELLING	**[ ]** AVOIDS READING
[ ] POOR, INEFFICIENT READING	**[ ]** FREQUENT LETTER, NUMBER OR WORD REVERSALS
[ ] MATH DIFFICULTY: FACTS/ CONCEPTS	

CURRENT ACADEMIC LEVELS (PLEASE CHECK APPROPRIATE BOX)

	ABOVE GRADE	ON GRADE	BELOW GRADE	SPECIAL HELP
READING				
READING COMPREHENSION				
SPELLING				
MATH				
HANDWRITING				

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:	APGAR SCORE:

WHEN DID YOUR CHILD BEGIN WALKING UNASSISTED?
WHEN DID YOUR CHILD BEGIN TO CRAWL?

WHEN DID YOUR CHILD BEGIN TO SPEAK 2-3 WORD PHRASES?

IS YOUR CHILD CLUMSY? **[ ] YES [ ] NO**	ANY SPEECH PROBLEMS NOW OR IN THE PAST? **[ ] YES [ ] NO**

ANY PROBLEMS WITH FINE MOTOR CO-ORDINATION? **[ ] YES [ ] NO**

DOES YOUR CHILD ENJOY, AND PARTICIPATE IN ACTIVITIES SUCH AS DRAWING, COLOURING, PUZZLES, BLOCK PLAY, ETC?
[ ] YES [ ] NO (WITH OLDER CHILDREN, DID THEY PREVIOUSLY?) **[ ] YES [ ] NO**