OFFICE USE ONLY
[ ] RTC VIP
[ ] TVPS

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):	GENDER:
HOME ADDRESS:	HEALTH CARD #:	
CITY:	PARENT/GUARDIAN'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		
HOW WERE YOU REFERRED TO US?	REASON FOR REFERRAL:	
INSURANCE INFO: Do you have insurance? [ ] Yes [ ] No [ ] unaware **Insurance Company: ________________________ Plan Member Name: ________________________** **Plan Member Birthday: ______________________ Policy/Group #: ____________________________** **Certificate/Member ID #:_____________________** [ ] **I GIVE** VISUAL SENSE EYE CARE PERMISSION TO COLLECT AND STORE MY INSURANCE INFORMATION AND TO SUBMIT MY EYE EXAM, GLASSES, AND/OR CONTACT LENS COST TO MY INSURANCE PLAN ON MY BEHALF.		
SIGNATURE OF CONSENT:	DATE OF CONSENT:	

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

PERSONAL VISUAL HISTORY & EYE HEALTH

[ ] BLURRED DISTANCE VISION / SQUINTING
[ ] BLURRED INTERMEDIATE VISION
[ ] BLURRED CLOSE VISION
[ ] SUDDEN VISION LOSS
[ ] DOUBLE VISION
[ ] FLOATING SPOTS
[ ] RED EYES
[ ] WATERY EYES/ BURNING EYES
[ ] FREQUENT HEADACHES
[ ] FLASHES OF LIGHT
[ ] DRY EYES
[ ] UNCOMFORTABLE CONTACT LENSES
[ ] AMBLYOPIA (LAZY EYE)
[ ] DROOPING EYELID
[ ] FLUCTUATING VISION
[ ] GLARE/ LIGHT SENSITIVITY
[ ] MUCUS DISCHARGE
[ ] STRABISMUS
[ ] CORNEAL TRANSPLANT
[ ] EYE TURN
[ ] KERATOCONUS
[ ] 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
[ ] POOR HANDWRITING
[ ] HOLDS BOOK TOO CLOSE
[ ] POOR SPELLING
[ ] POOR, INEFFICIENT READING
[ ] MATH DIFFICULTY: FACTS/ CONCEPTS
[ ] WORDS MOVING OR RUNNING TOGETHER
[ ] DIFFICULTY COPYING FROM THE BOARD
[ ] POOR READING COMPREHENSION
[ ] AVOIDS READING
[ ] FREQUENT LETTER, NUMBER OR WORD REVERSALS

CURRENT ACADEMIC LEVELS (PLEASE CHECK APPROPRIATE BOX)

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

DEVELOPMENTAL HISTORY

<table>
<tr><td colspan="2">WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DURING BIRTH? [ ] YES [ ] NO IF YES, PLEASE DESCRIBE:</td></tr>
<tr><td colspan="2">WAS YOUR CHILD BORN PREMATURELY? [ ] YES [ ] NO IF YES, HOW SOON?</td></tr>
<tr><td>CHILD’S BIRTH WEIGHT:</td><td>APGAR SCORE:</td></tr>
<tr><td colspan="2">WHEN DID YOUR CHILD BEGIN WALKING UNASSISTED?
WHEN DID YOUR CHILD BEGIN TO CRAWL?</td></tr>
<tr><td colspan="2">WHEN DID YOUR CHILD BEGIN TO SPEAK 2-3 WORD PHRASES?</td></tr>
<tr><td>IS YOUR CHILD CLUMSY? [ ] YES [ ] NO</td><td>ANY SPEECH PROBLEMS NOW OR IN THE PAST? [ ] YES [ ] NO</td></tr>
<tr><td colspan="2">ANY PROBLEMS WITH FINE MOTOR CO-ORDINATION? [ ] YES [ ] NO</td></tr>
<tr><td colspan="2">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</td></tr>
</table>