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Welcome to the Practice - Children

In order to allow me more time to devote to the assessment of your child, it would be appreciated if you could complete the following information -

CHILD's NAME: _____ **DOB:** _____

SCHOOL: _____ **YEAR:** _____

PARENT NAME: _____ **EMAIL:** _____

Developmental Testing	Yes	No
Did your child come when expected? If not please check: ☐ Premature ☐ Overdue		
Did you have a normal delivery? ☐ Caesarean ☐ Forceps		
Was your child well after birth? ☐ Humidicrib ☐ Phototherapy for Jaundice		
Did your child gain weight normally?		
Did your child crawl on hands and knees? If yes at what age? _____		
When did your child say his/her first words? _____ Months		
When did your child first speak in sentences? _____ Months		
What is your child's preferred hand? ☐ Right ☐ Left		
Do you consider your child's general co-ordination to be as expected for his/her age? (Includes catching skills)		

General Health	Yes	No
Has your child had any serious illness or injury requiring hospitalisation? If yes please detail: _____		
Does your child suffer from any other recurrent or chronic illness, eg Asthma, Epilepsy? If yes please summarise: _____		
Are any medications currently being taken? If yes please detail: _____		
Has your child had (a) Speech Therapy &/or (b) Occupational Therapy? If yes, at what age, type, and for how long? _____		
Is there any history of Strabismus/Amblyopia (Lazy Eye) in the family?		

Visual History	Yes	No
Is there any unusual redness of eyes or lids?		
Does your child get frequent styes or sores on eyelids?		
Does one eyelid droop, especially when tired?	R or L	
Does one eye turn in or out? If yes, please detail _____	R or L	
Does your child dislike bright light, especially when outside?		

Does your child squint with one eye when in bright light?	R or L	
Has your child had any previous visual examination? If yes, any treatment; glasses/ exercise/eye patch/ other referral? _____		

Educational History

	Yes	No
Does your child have difficulty with ☐Reading ☐Writing ☐Spelling ☐Maths		
Has your child repeated a grade?		
Has there been any remedial teaching?		

*Tick the box next to any problem that seems to occur **OFTEN** for your child.*

SIGNS OF EYE TEAMING PROBLEMS

Covers or closes one eye when reading		Child complains of words moving on page	
Child complains of eye strain		Inattentive	
Child complains of headaches		Poor reading comprehension	
Child complains of double vision		Loses place	

SIGNS OF FOCUSING PROBLEMS

Child complains of blurred vision when reading		Child complains of blurred vision looking from desk to board	
Child complains of headaches		Rubs Eyes	
Poor reading comprehension		Inattentive	
Is overtired at the end of the school day		Holds things very close	

SIGNS OF TRACKING PROBLEMS

Skips lines and words often		Short attention span when reading	
Loses place often		Uses finger to keep place	

SIGNS OF VISUAL PROCESSING DISORDERS

Trouble learning from left to right		Untidy writing	
Reverses letters and numbers		Trouble copying from board to book	
Mistakes words with similar beginnings		Fails to recognise the same words repeated on a page	
Poor recall of visually presented material		Trouble with spelling and sight word vocabulary	
Slow copying and completing worksheets		Seems to know material but does poorly on written tests	
Can respond orally but not in writing		Erases excessively	
Trouble learning basic maths concepts of size and magnitude		Poor reading comprehension	

How did you first hear about our practice?

☐ Internet ☐ Friend ☐ Family ☐ Walk By ☐ GP ☐ Other _____

Our practice respects your privacy and will comply with the Privacy Act and the National Privacy Principles when handling your personal information. We use your personal information only to provide services to you and send you information regarding eye health, eye care and eyewear. If you do not provide information requested in this form we may be unable to provide services to you or our ability to do so may be impaired. You can access most personal information that we hold about you. Please contact us if you would like to know more about how we handle your personal information.

Signature: _____ Date: _____