Beyond 20/20
Vision Therapy

Functional Vision Evaluation - Child

Child's Name: ______________________________ Preferred Name: ______________________
Date of Birth: _____________ Age: __________ Gender: M F
Home Address: _________________________ City: ______________________ Zip: ____________
Home Telephone: ________________________ School Name: ___________________________
Current Grade: _________ Has a grade been repeated? ▢ No ▢ Yes - which ________
Type of Classroom: ( ) Regular Education ( ) Special Education ( ) Other: _________
Teacher's Name: ______________________________

Father's First Name: ____________________ Father's Last Name: ______________________
Father's Telephone: Home: ( ) __________ Cell: ( ) __________ Work: ( ) ____________
Father's Occupation: ____________________ E-mail: ___________________________________
Mother's First Name: ____________________ Mother's Last Name: ______________________
Mother's Telephone: Home: ( ) __________ Cell: ( ) __________ Work: ( ) ____________
Mother's Occupation: ____________________ E-mail: ___________________________________

Who may we thank for referring you? ____________________ Profession: ______________
Address: ________________________________ Phone: _________________________________

ACCOUNT RESPONSIBLE INFORMATION
Person responsible for payment: Mother ( ) Father ( ) Other ( ) _______________
Phone number: ______________________________________

VISION HISTORY
Last Eye Examination Date: _______________ Name of Doctor: ______________________
Were glasses prescribed? ▢ No ▢ Yes, to be worn: ______________________________
Are contact lenses worn? ▢ No ▢ Yes, How are they worn? _____________________
Other Recommendations Given: ____
What is the main reason for bringing your child for a functional vision evaluation?

____

____

Have you ever been told your child has a visual problem in the past? ▢ Yes ▢ No
If yes, who? (ie: school evaluation, psychological evaluation, vision exam)

____

Does your child report any of the following?	No	Yes
Blurred distance vision	▢	▢
Blurred near vision	▢	▢
Eyestrain or visual fatigue	▢	▢
Headaches	▢	▢
Sensitivity to sunlight or bright lights	▢	▢
Double vision	▢	▢
Words split or move on the page	▢	▢
Eyes hurt	▢	▢
Car sickness/motion sickness	▢	▢

Do you or others notice any of the following with your child?	No	Yes
Covers or closes one eye with near tasks	▢	▢
Dislikes school or academic related tasks	▢	▢
Eye appears to turn inward/outward	▢	▢
Fidgets in chair with near activities	▢	▢
Puzzles are difficult or challenging	▢	▢
Difficulty sustaining attention with near activities	▢	▢
Concern, or diagnosed with ADD or ADHD	▢	▢
Avoids looking at books	▢	▢
Brings books/paper/tablet very close to eyes	▢	▢
Confuses left and right	▢	▢
Reverses letters/numbers excessively (ie: b/d, S/5)	▢	▢
Translates numbers (125/152)	▢	▢
Difficulty retaining letters, numbers, colors learned	▢	▢
Needs a lot of repetition with learning new skills	▢	▢
Poorly organized handwriting	▢	▢
Avoids writing or drawing	▢	▢
Handwriting is slow to develop	▢	▢
Poor eye-hand coordination with sports	▢	▢
Frequently erases	▢	▢
Clumsy; bumps into things often	▢	▢
Frequently says “I can’t” before trying a task	▢	▢

Has your child ever had:	No	Yes	When/with whom?
Eye Surgery	▢	▢	____________________
Eye Patching	▢	▢	____________________
Eye Injury	▢	▢	____________________
Vision Therapy	▢	▢	____________________

MEDICAL HEALTH HISTORY

Is your child generally healthy? ▢ Yes ▢ No, please explain: ________________

____

Has your child ever had any bad falls, concussions, significant illness, high fevers or seizures of any sort in the past? If yes, please describe:

____

Does your child have/take any of the following?

	No	Yes	Please describe
Medications	▢	▢	________________________
Vitamins/supplements	▢	▢	________________________
Allergies to medications	▢	▢	________________________
Allergies to food	▢	▢	________________________
Seasonal allergies	▢	▢	________________________
Frequent ear infections	▢	▢	________________________
Anxiety/depression/fears	▢	▢	________________________

Pediatrician's Name: ___________________________Date of Last Visit: __________

Office Location/Hospital: _______________________Phone: ___________________

Has your child ever been diagnosed as having:

▢ Learning Disabilities ▢ Developmental Delays

▢ ADD or ADHD ▢ Cerebral Palsy

▢ Seizure Disorders ▢ Autism

▢ Other ____

Has your child ever been evaluated by the following professionals?

Neurologist ▢ Yes ▢ No

Name: ____________________________Date of Last Visit: ________________

Office Location: ________________________Phone: _______________________

Results/recommendations given: ____

Psychologist ▢ Yes ▢ No

Name: ____________________________Date of Last Visit: ________________

Office Location: ________________________Phone: _______________________

Results/recommendations given: ____

Occupational Therapist ▢ Yes ▢ No

Name: ____________________________Date of Last Visit: ________________

Office Location: ________________________Phone: _______________________

Speech Therapist ▢ Yes ▢ No
Name: ____________________________ Date of Last Visit: _______________
Office Location: _______________________ Phone: ______________________

Audiologist ▢ Yes ▢ No
Name: ____________________________ Date of Last Visit: _______________
Office Location: _______________________ Phone: ______________________

Other: ________________________________ ▢ Yes ▢ No
Name: ____________________________ Date of Last Visit: _______________
Office Location: _______________________ Phone: ______________________

Does your child or family member have any of the following?

	Child	Family	Whom?
Diabetes	▢	▢	________________________
High Blood Pressure	▢	▢	________________________
Thyroid Disease	▢	▢	________________________
Multiple Sclerosis	▢	▢	________________________
Genetic Abnormalities	▢	▢	________________________
Epilepsy or Seizures	▢	▢	________________________
Glaucoma	▢	▢	________________________
Macular Degeneration	▢	▢	________________________
Amblyopia (lazy eye)	▢	▢	________________________
Crossed or wall eye	▢	▢	________________________
Dyslexia	▢	▢	________________________

DEVELOPMENTAL HISTORY

Full-term pregnancy? ▢ Yes ▢ No, __________weeks
Any complications during pregnancy or delivery? ▢ No ▢ Yes _______________
Any complications immediately after birth? ▢ No ▢ Yes _____________________
Oxygen after birth? ▢ No ▢ Yes, how long? ______________________
Birth weight: ________________ Birth length: ___________________
At what age did your child achieve the following milestones: Rolling over: ___________
Sitting up: _________ Crawl: _________ Walk: _________ Verbalize Sounds: _______
Has your child had early intervention services? ▢ No ▢ Yes, please describe:
____
How would you describe your child's gross motor skills? (ie: running, jumping, hopping)
____
How would you describe your child's fine motor skills? (ie: cutting, tying shoes)
____

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EDUCATIONAL HISTORY

Does your child enjoy school? ▢ Yes ▢ No

Does the teacher express any particular concerns with how your child is progressing in school? ▢ No ▢ Yes

Please describe: ____

What services is your child currently receiving **in school**? Please check all that apply:

Occupational Therapy:	▢ No	▢ Yes No. times per week: _____
Physical Therapy:	▢ No	▢ Yes No. times per week: _____
Speech Therapy:	▢ No	▢ Yes No. times per week: _____
Reading Support:	▢ No	▢ Yes No. times per week: _____
Math Support:	▢ No	▢ Yes No. times per week: _____

Other: Please describe: ____

What services is your child currently receiving privately **outside of school**? Please check all that apply:

Occupational Therapy:	▢ No	▢ Yes No. times per week: _____
Physical Therapy:	▢ No	▢ Yes No. times per week: _____
Speech Therapy:	▢ No	▢ Yes No. times per week: _____
Reading Support:	▢ No	▢ Yes No. times per week: _____
Math Support:	▢ No	▢ Yes No. times per week: _____

Other: Please describe: ____

Please check all behaviors that apply to your child:

- ▢ Homework takes an extremely long time for my child to complete
- ▢ Procrastinates with starting schoolwork and homework
- ▢ Not independent with homework; I must sit with my child in order for him/her to complete it
- ▢ Does not enjoy looking at books for pleasure
- ▢ Enjoys being read to by parent, but will not pick up books on his/her own
- ▢ Class clown
- ▢ Appears unmotivated and lazy with academic tasks
- ▢ Has low self-esteem and thinks s/he is stupid
- ▢ Is highly verbal and has a lot of knowledge, yet is not achieving in the classroom

Currently, what are your child's average grades overall?

A B C D F

School work/grades in the following classes are at which level? (please check)

	Above Average	Average	Below Average
Reading	________	________	________
Math	________	________	________
Spelling	________	________	________
Writing	________	________	________
Gym	________	________	________

GENERAL BEHAVIOR

Are there any behavior problems?

School: ______________________ Home: ______________________

What causes these problems? ____

How does your child respond to tension: ▢ thumb sucking ▢ nail biting

▢ other: __________________________

Is there anything else you would like to share that concerns you about your child?

____

____

____

FINANCIAL POLICY

We require payment at the time of the visit. We will provide you with a detailed receipt at the completion of each session for insurance reimbursement submission.

Please sign that you understand the above:

Signed: ______________________________________ Date: _____________________

(Parent or Guardian)