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**PATIENT INFORMATION**

Name (First, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:      Female      Male

Address: \_\_\_\_\_

City/State/Zip code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact name & number: \_\_\_\_\_

Did anyone refer you to us? (please list name/office): \_\_\_\_\_

**FAMILY BACKGROUND**

Adult(s) in household consist of (please indicate and include names):

Father / Stepfather / Grandfather : \_\_\_\_\_

Mother / Stepmother / Grandmother: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Please list any siblings and their ages: \_\_\_\_\_

Please list any family history of learning disorders, ADHD, autism: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHOOL**

Name of School: \_\_\_\_\_ Current grade: \_\_\_\_\_

Please list any grades that have been repeated: \_\_\_\_\_

School work is:      \_\_\_ below average      \_\_\_ average      \_\_\_ above average

Favorite school subjects: \_\_\_\_\_

Least favorite school subjects: \_\_\_\_\_

Please indicate if your child has a 504 plan or IEP as well as any accommodations or special services included with these plans (reading specialist, OT/PT/Speech):

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Does your child receive any tutoring services? If yes, please indicate which subjects:

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**GENERAL BEHAVIORAL AND SOCIAL SKILLS**

Activity level:      \_\_\_ high      \_\_\_ average      \_\_\_ low

Please list any behavior problems reported at school or home and any factors that appear to elicit behaviors:

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Please list any aversions to sensory input (lighting, noise, etc: )

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Describe the quality of relationships with:

Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Classmates: \_\_\_\_\_

**MEDICAL HISTORY**

**VISUAL HEALTH**

Last eye exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last dilation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility/Doctor's name: \_\_\_\_\_

Please list any vision related conditions you have been previously diagnosed with:

\_\_\_\_\_

Please indicate if you wear glasses or contact lenses? \_\_\_\_\_

If your child wears glasses, please indicate at what age the lenses were prescribed: \_\_\_\_\_

**GENERAL HEALTH**

Last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility/Doctor's name: \_\_\_\_\_

Please list any conditions you have been diagnosed with: \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are currently taking and for what condition:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had concussion or head injury? If yes, please indicate what age and a brief description and any treatment services you have received

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Please list any allergies:

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### BEHAVIORAL HEALTH

If your child has had a neurological and/or psychological evaluation, please answer the following questions:

Facility/Doctor name: \_\_\_\_\_

Exam Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Please list any treatment that was received: \_\_\_\_\_

### DEVELOPMENT HISTORY

Please list any complications before/during/immediately following birth:

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Age at which your child first crawled: \_\_\_\_\_ 1<sup>st</sup> step      \_\_\_\_\_ 1<sup>st</sup> word

**Please indicate any development therapy services your child has received:**

**Provider**

**Duration**

**Occupational therapy:** \_\_\_\_\_

**Physical therapy:** \_\_\_\_\_

**Speech therapy:** \_\_\_\_\_

**Social work/counseling:** \_\_\_\_\_

**Other:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please rate the following symptoms as 0 = never, 1 = occasionally, 2 = often, 3 = always.

1. Blur when looking at near \_\_\_\_\_
2. Headaches with near work \_\_\_\_\_
3. Dizziness or nausea with near work \_\_\_\_\_
4. Avoids near work/reading \_\_\_\_\_
5. Difficulty copying from board to paper \_\_\_\_\_
6. Double vision \_\_\_\_\_
7. Words moving or overlapping on a page \_\_\_\_\_
8. Skips or repeats lines when reading \_\_\_\_\_
9. Misaligns digits/columns of numbers \_\_\_\_\_
10. Closes one eye or tilts head while reading \_\_\_\_\_
11. Poor reading comprehension \_\_\_\_\_
12. Trouble keeping attention on reading \_\_\_\_\_
13. Prefers being read to rather than reading \_\_\_\_\_
14. Difficulty with sight word recognition \_\_\_\_\_
15. Poor spelling ability \_\_\_\_\_
16. Reversals letters such as b/d/p/q \_\_\_\_\_
17. Poor handwriting \_\_\_\_\_
18. Poor hand-eye coordination \_\_\_\_\_
19. Clumpsiness/knocks things over \_\_\_\_\_
20. Takes longer than expected to complete assignments \_\_\_\_\_



**ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES**

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**Notice to Patient:**

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and /or disclose your health information. You are entitled to a copy of our Notice of Privacy Practices, which is available in our office. Please let us know if you would like to have a copy of Everett Vision Therapy Privacy Practices.

I also give my consent for Everett Vision Therapy to communicate appointment reminders and forms via email/text unless indicated otherwise below.

I do NOT want to receive communication from Everett Vision Therapy via email or text.

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**Print name of patient**

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**Signature of patient ( or parent/guardian if patient is a minor)**

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**Print name of parent/guardian (if signing for a minor)**

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**Date**



**INSURANCE CLAIM AUTHORIZATION FORM**

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**By signing this statement, you are authorizing Everett Vision Therapy to complete any necessary insurance claim forms on your behalf. You are hereby also authorizing the release of any medical or other relevant information which may be needed in order to process your claims. Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services you have received.**

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**Patient Name**

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**Name of Policy holder (if different from patient)**

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**Policy holder DOB (MM/DD/YYYY)**

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**Signature of Patient/Authorized Person**

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**Date**



PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

This document allows Everett Vision Therapy to release the medical records of the above mentioned patients to the parties specified below.

1. Optometrist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

2. OT/PT/SPEECH therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

3. Teacher: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

4. Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Patient/guardian

DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_