

VISION THERAPY AT EYECENTER

Please complete the following history to assist us with performing a thorough exam:

PATIENT's Name _____ Age _____ DOB ____/____/____ M / F

Address: _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ City _____ Zip _____ Cell Phone (____) _____ - _____

Signing this document signifies that you have RECEIVED a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operation involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail.

I acknowledge that I have RECEIVED the Notice of Privacy Practices from Eye Center Optometric.

_____ Date _____ Signature _____
 If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign.
 _____ Relationship to Patient _____ Print Name _____

School/Grade/Teacher _____

Describe current visual/academic concerns: _____

Please circle Y for yes & N for no, followed by a description of when the following occurs:

- | | | | |
|---------------------------|---|---|-------|
| Headaches | Y | N | _____ |
| Blurred Vision | Y | N | _____ |
| Double Vision | Y | N | _____ |
| Eyes hurt, tired | Y | N | _____ |
| Holds reading close | Y | N | _____ |
| Writes close | Y | N | _____ |
| Closes one eye | Y | N | _____ |
| Covers one eye | Y | N | _____ |
| Frequent red eyes | Y | N | _____ |
| Excessive eye rubbing | Y | N | _____ |
| Excessive blinking | Y | N | _____ |
| Loses place when reading | Y | N | _____ |
| Tilts head when reading | Y | N | _____ |
| Poor posture when reading | Y | N | _____ |
| Inability to see far away | Y | N | _____ |
| Bumping into objects | Y | N | _____ |
| Poor Coordination | Y | N | _____ |
| Enlarged Pupils | Y | N | _____ |
| Light Sensitivity | Y | N | _____ |
| Behavior Problems | Y | N | _____ |

Previous eye exams? At age _____ Doctor _____ Result _____

Started Kindergarten at age _____ Likes school? Y N Any grade repeated? _____

School work is: Above average Average Below average Difficult subjects: _____

Easy subjects: _____ Enjoys reading? Y N

Normal birth history and development? Y N (explain) _____

Brief description of child as a person: _____