INSPIRE
VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

LEARNING RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ Male / Female

Date of Birth: _____ (M/D/Y) Age: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Email: _____

Parent's Names _____ & _____

Parent's Cell Number _____ & _____

Family Doctor: _____ Referred by: _____

Health Card #: _____ VC_____

Last Eye Exam: _____ Optometrist: _____

Grade: _____ School: _____

Individualized Education Program: YES / NO

HEALTH HISTORY

Please list any current medical conditions: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Is your child generally healthy? YES / NO

Is there a history of bad fall(s) that resulted in a head injury? YES / NO
If Yes, was it considered Mild, Moderate or Severe: _____

Is there a history of high fevers? YES / NO
If Yes, was it considered Mild, Moderate or Severe: _____

What was the frequency of the fevers? _____

Is there a history of chronic ear infections? YES / NO
If Yes, was it considered Mild, Moderate or Severe: _____

Did your child have tubes put in? YES / NO

Did your child have surgery to treat the ear infections? YES / NO

DEVELOPMENTAL HISTORY

Did mother experience any health problems during the pregnancy? YES / NO
If YES, please explain: _____

Were there any complications with the birth? YES / NO
If YES, please explain: _____

Was the child born premature? YES / NO
If yes, what was the length of pregnancy? _____

Did your child crawl? YES / NO
What type of crawl did your child do? Please circle
Stomach on floor On all fours Bum scooted

At what age did your child walk? _____

Were there any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, skipped crawling, toe walking etc.)? YES / NO
If yes, please explain: _____

Any current or past speech problems: YES / NO
What age did your child say their first word? _____
Was early speech clear to others? _____
Is speech clear now? YES / NO

Receiving any special development assistance? OT PT Speech Other

If ADD/ADHD or a Learning Disability or Dyslexia was diagnosed, who diagnosed it, how was it diagnosed and when?

_____
_____
_____
_____

SCREEN TIME

Does your child watch television? YES / NO
How many hours a week does your child watch television? _____

Does your child play video games? YES / NO
How many hours a week does your child play video games? _____

Does your child use a smartphone/tablet? YES / NO
How many hours a week does your child spend on the smartphone/tablet? _____
How is your child likely to use the smartphone/tablet? (Please circle all that apply)
Play games Watch videos Social media Other

OBSERVATIONS

Physical Signs / Complaints	**YES**	**NO**	**COMMENT**
Headaches, especially after near work	☐	☐	_____
Exhausted after day of school	☐	☐	_____
Car sickness	☐	☐	_____

Blurry vision, even with glasses	☐	☐	_____
Frequently rubs eyes	☐	☐	_____
Turns head to side when watching TV	☐	☐	_____
Tilts or turns head during deskwork	☐	☐	_____
Closes/covers an eye during deskwork	☐	☐	_____
Head gets close to reading material	☐	☐	_____

Reading	**YES**	**NO**	**COMMENT**
Words run together, move, or double when reading	☐	☐	_____
Skips, repeats lines when reading	☐	☐	_____
Uses finger to maintain place	☐	☐	_____
Omits words when reading	☐	☐	_____
Slow reader compared to peers	☐	☐	_____
Difficulty reading words (decoding)	☐	☐	_____
Tires rapidly and loses attention when reading	☐	☐	_____
Poor comprehension	☐	☐	_____
Dislikes chapter books	☐	☐	_____
Reads well for short time, then slows	☐	☐	_____

Writing / Drawing	**YES**	**NO**	**COMMENT**
Difficulty copying from board	☐	☐	_____
Copying takes longer than normal	☐	☐	_____
Copies words backwards	☐	☐	_____
Reverses numbers, letters, or words	☐	☐	_____
Writes up/ down hill	☐	☐	_____
Misaligns digits/columns of numbers	☐	☐	_____
Poor pencil grip	☐	☐	_____

Mathematics	**YES**	**NO**	**COMMENT**
Difficulty learning to count	☐	☐	_____
Poor memory for numbers	☐	☐	_____
Difficulty with math problem-solving skills	☐	☐	_____
Difficulty reading clocks with hands	☐	☐	_____

Attention	**YES**	**NO**	**COMMENT**
Attention better when listening rather than reading	☐	☐	_____
Constantly fidgets	☐	☐	_____
Homework is a battle; can’t concentrate	☐	☐	_____
Poor eye contact; appears to not be listening	☐	☐	_____
Can’t locate belongings/ things or forgets	☐	☐	_____

Behaviour	**YES**	**NO**	**COMMENT**
Does not socialize well with other children	☐	☐	_____
Does not like going to school	☐	☐	_____
Difficult to discipline at home	☐	☐	_____
Poor organizational skills	☐	☐	_____

Easily distracted	☐	☐	_____
Anxious frequently	☐	☐	_____
New situations/events (transitions) difficult	☐	☐	_____
Under fatigue/stress, child withdraws	☐	☐	_____
Frequently says “I can’t” before trying	☐	☐	_____
Feels “stupid,” poor confidence	☐	☐	_____

Coordination	**YES**	**NO**	**COMMENT**
Clumsy, poor balance	☐	☐	_____
Falls frequently or trips	☐	☐	_____
Often knocks things over, esp. at table (messy eater)	☐	☐	_____
Difficulties learning bike riding	☐	☐	_____
Can’t keep eye on ball, or hit a ball (catching, batting)	☐	☐	_____
Reads a lot, avoids exercise	☐	☐	_____
Difficulty with puzzles	☐	☐	_____

FAMILY & HOME

Please indicate who your child lives with: (Please circle all that apply)

Mother	Father	Siblings	Stepmother	Stepfather
Adoptive Parents	Grandmother	Grandfather	Aunt	Uncle
Foster Parents				

Other caretaker (please specify): _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? _____
If YES, at what age did it occur? _____

Did the father or anyone in the father’s family have a learning problem? YES / NO
If YES, who? _____

Did the mother, or anyone in the mother’s family have a learning problem? YES / NO
If YES, who? _____

Do any, or did any, of the other children in the family have a learning problem? YES / NO
If YES, Who? _____

Please list all extracurricular activities your child is currently engaged in (sports, swimming, music, gymnastics, dance etc.)

_____ Hours per week: _____
_____ Hours per week: _____
_____ Hours per week: _____

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