Thompson Optometry

Child Information

If you are a healthcare professional and would like to refer your patient to our clinic for Vision Therapy, please complete the intake form below and email to **vtadmin@thompsonoptometry.ca** or print completed form and fax to **(905) 793-8528**. Please allow 48 business hours to process referrals.

Patient Full Name:			
Patient Address:			
City:		**Postal Code:**	
Cell Phone:		**Gender:**	◯ **M** ◯ **F**
Email:			
OHIP #:		**Version Code:**	
Date of Birth:	MM / DD / YYYY	**When was your last exam?**	MM / DD / YYYY
Who was the Eye Doctor?			

Your Child's Medical History:

- ☐ Autism/ASD/Aspersers
- ☐ ADD/ADHD
- ☐ Developmental Delay
- ☐ Premature
- ☐ Tubes in ears
- ☐ Broken bones
- ☐ Diabetes
- ☐ Asthma
- ☐ Other_____
- ☐ List medication _____

  _____
- ☐ List Allergies _____

  _____

Your Child's Eye History:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Colour blindness
- ☐ Turned or wandering eye
- ☐ Eye surgery
- ☐ Dry eye
- ☐ Lazy eye
- ☐ Vision therapy
- ☐ Eye injury

Does Your Child Currently Have:

- ☐ Trouble seeing distance
- ☐ Trouble reading
- ☐ Blur
- ☐ Headaches
- ☐ Achy eyes
- ☐ Light sensitivity
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Watering eyes
- ☐ Itchy eyes
- ☐ Tired eyes/ Burning eyes
- ☐ Double vision
- ☐ Flashes
- ☐ Spots
- ☐ Nausea
- ☐ Dizziness

Thompson Optometry

Family Eye / Family Medical Problems

_____
_____
_____
_____

Does Your Child Use:

- ☐ Eye drops
- ☐ Eye Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Hot compresses
- ☐ Eye patch

Reading

- ☐ Above Grade
- ☐ On Grade
- ☐ Below Grade

Educational History

Current School:

_____

Grade:_____

Is your child receiving any tutoring, extra help or special classes?

- ☐ Yes
- ☐ No

Does your child have an IEP?

- ☐ Yes
- ☐ No

Printing/ Writing/ Spelling

- ☐ Above Grade
- ☐ On Grade
- ☐ Below Grade

Does your child experience any of the following when printing/ writing/ spelling?

- ☐ Letter Reversals
- ☐ Difficulty copying from board
- ☐ Poor printing
- ☐ Poor cursive writing
- ☐ Poor Spelling
- ☐ Other_____

Does your child experience any of the following when reading?

- ☐ Loss of place
- ☐ Words move or running together
- ☐ Poor reading comprehension
- ☐ Word reversals
- ☐ Avoids reading
- ☐ Poor, inefficient reading
- ☐ Holds book close
- ☐ Headaches
- ☐ Other _____

Math

- ☐ Above Grade
- ☐ On Grade
- ☐ Below Grade

Does your child experience any of the following when doing Math?

- ☐ Difficulty with word problems
- ☐ Misaligns numbers
- ☐ Difficulty with addition
- ☐ Difficulty with fractions
- ☐ Difficulty with multiplication

Gym/ Sports/ Coordination

- ☐ Above Grade
- ☐ On Grade
- ☐ Below Grade

Does your child experience any of the following when participating in gym/ sports/ coordination?

- ☐ Eye-hand difficulty (kicking, throwing, catching)
- ☐ Difficulty with fine motor control (manipulation with

Developmental History

Were there any complications with pregnancy or during birth?

- ☐ Yes
- ☐ No

If yes, please describe

_____
_____

Was your child born prematurely?

- ☐ Yes
- ☐ No

Was your child born prematurely?

Thompson Optometry

☐ Difficulty with geometry ☐ Other_____	hands/fingers) ☐ Difficulty with gross motor control (running, hopping) ☐ Skipping and rhythm ☐ Balance problems ☐ Other_____	☐ Yes ☐ No **If yes, how soon? _____** **Child's birth weight: _____** **When did your child begin walking unassisted? _____** **When did your child begin toilet training? _____** **When did your child begin to say 2-3 word phrases? _____**
Any speech problems now or in the past? ☐ Yes ☐ No **Does/did your child enjoy and participate in activities such as drawing, colouring, puzzles, block play, etc.?** ☐ Yes ☐ No	**At Home Habits** ☐ Has a messy room ☐ Has trouble tying their shoes ☐ Is typically a messy eater ☐ Has difficulty using forks and knives ☐ Often forgetful ☐ Often clumsy ☐ Difficulty following verbal directions	**Other Necessary Information** _____ _____ _____ _____ _____ _____ _____ _____ _____