

Welcome to Our Practice

Personal Details

Child's Full Name Male [] Female []
Parent/Guardian's Name Male [] Female []
Address Postcode
Parent/Guardian's Email Child's Date of Birth / /
Parent/Guardian's Mobile
Child's Medicare Number Ref Number Expiry Date / /
Is your child covered by Private Health Insurance? Yes [] No []
Private Health Fund Provider
GP's Name GP's Phone
GP's Address Postcode
What is the main reason for your visit today?
.....
.....

Medical History



Has your child previously be assessed by any of the following?

Educational Psychologist [] Audiologist [] Speech Pathologist []
Occupational Therapist [] Ophthalmologist [] Paediatrician []

Has your child been diagnosed with any behavioural or learning difficulties? Yes []...No []

If yes, please specify:

Does your child currently wear glasses? Yes []... No []

Does your child have other health conditions we should be aware of?
.....
.....

Please list any medications your child is currently taking:
.....
.....

Education



Name of School

Year Level

Is your child having difficulty with any of the following?

Reading [] Spelling [] Writing [] Maths [] Behaviour []

Has your child repeated a grade? Yes []...No []

Birth and Development



Did you experience any complications during birth? Yes []... No []

If yes, please specify:

At what age did your child start to crawl?

At what age did your child start to talk?

Is your child right handed or left handed? Left [] . Right []

Eye Teaming Ability

Does your child:

- Complain of double vision.....Yes []..No []
- Complain of eye strain.....Yes []..No []
- Complain of headachesYes []..No []
- Complain of moving words on the page...Yes []..No []
- Cover or close one eye when reading.....Yes []..No []
- Have an eye that turns inward or outward constantly when tiredYes []..No []
- Have head at an angle when readingYes []..No []
- Lose place when reading.....Yes []..No []
- Have poor reading comprehension.....Yes []..No []
-

Focusing Ability

Does your child:

- Avoid small print.....Yes []..No []
- Become fatigued when readingYes []..No []
- Complain of blurred vision when reading ...Yes []..No []
- Complain of eye strain.....Yes []..No []
- Complain of headachesYes []..No []
- Have a short attention span when reading Yes []..No []
- Hold a book very closeYes []..No []
- Have poor reading comprehension.....Yes []..No []
- Rub his or her eyes when concentrating Yes []..No []
-

Tracking Ability

Does your child:



- Have a short attention span when reading .Yes []..No []
- Lose place on page often.....Yes []..No []
- Skip words and lines often.....Yes []..No []
- Use fingers to keep place.....Yes []..No []
-

Visual Processing Ability


Does your child:

- Respond orally but not in writingYes []..No []
- Have difficulty following a series of instructionsYes []..No []
- Not recognise the same word repeated on a pageYes []..No []
- Have trouble learning left and right.....Yes []..No []
- Have untidy handwritingYes []..No []
- Mistake words with similar beginningsYes []..No []
- Have poor organisation on a page.....Yes []..No []
- Have poor reading comprehension.....Yes []..No []
- Have poor recall of visual materialYes []..No []
- Reverse letters and numbers.....Yes []..No []
- Seem to know material but does poorly on written materialYes []..No []
- Copy from the board to their book slowly..Yes []..No []
- Have trouble learning letter/sound correspondence.....Yes []..No []
- Have trouble learning basic mathYes []..No []
- Have trouble with spelling and sight word vocabularyYes []..No []
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How did you hear about us?

- | | |
|---|-------------------------------------|
|  Relative / Friend / Previous Patient.....Yes [] | Facebook / Social Media.....Yes [] |
|  Your GP.....Yes [] | Print Advert.....Yes [] |
| Internet Search / Our Website.....Yes [] | Other |
-

Future communication

-  Are you happy to receive occasional communications including appointment reminders, eye health information and special offers by mail, email and sms?.....Yes [].....No []

Signature

Date / /

Thank you for entrusting us with your eyecare

Privacy Statement: Our practice respects your privacy and will comply with the Privacy Act and the Australian Privacy Principles when handling your personal information (including health information). We use your personal information to help us provide services to you. We may also use your personal contact information to send you information regarding eye health, eye care and eyewear, with your consent. By providing the information requested in the first three sections of this form we will be able to make an informed decision on how to best meet your eye care and eyewear needs. We may also need to provide some personal information to third party suppliers (such as providers of mail-out and electronic distribution services and eyewear suppliers) if and to the extent necessary for them to provide the relevant goods or services (for example prescription eyewear or contact lenses). You can access all the personal information that we hold about you. Please contact us if you would like to know more about how we handle personal information or to see or obtain a copy of our full privacy policy.
