

FAMILY VISION THERAPY SERVICES

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Child's full name: _____ Social Security #: _____
Date of Birth _____ Age Now: _____
Complete Address: _____
Home Phone: _____ Business Phone: _____
Parents Names: _____ Occupations: _____
Name of School: _____ Grade: _____
Address: _____ Teachers Name: _____
By Whom Referred: _____

PRESENT SITUATION: In what ways does your child seem to have difficulty?

How does your child complain about his or her vision?

Has anyone noticed an eye turn in or wander out? _____ Which eye? _____ When? _____

Does your child ever report any of the following, and if so, when?

Headaches	Yes _____	No _____	When? _____
Blurred Vision Far	Yes _____	No _____	When? _____
Blurred Vision Near	Yes _____	No _____	When? _____
Double Vision	Yes _____	No _____	When? _____
Eyes hurt or tired	Yes _____	No _____	When? _____

Have you ever noticed the following?

Holding reading close?	Yes _____	No _____	When? _____
Closing one eye?	Yes _____	No _____	When? _____
Covering one eye?	Yes _____	No _____	When? _____
Eyes frequently reddened?	Yes _____	No _____	When? _____
Frequent styes?	Yes _____	No _____	When? _____
Excessive eye rubbing?	Yes _____	No _____	When? _____
Get lost in book?	Yes _____	No _____	When? _____
Reads with a finger?	Yes _____	No _____	When? _____
Distorted posture when reading?	Yes _____	No _____	When? _____
Inability to see distance objects?	Yes _____	No _____	When? _____
Bumping into objects?	Yes _____	No _____	When? _____
Poor general coordination?	Yes _____	No _____	When? _____
Bothered by light?	Yes _____	No _____	When? _____

School:

Age at time of entrance? _____ Kindergarten _____ First Grade _____

Does child like school? _____ Was a grade repeated? _____ Which one? _____

Is school work: average better than average below average

Have there been any school difficulties? _____

What subjects are considered easiest? _____ most difficult? _____

Developmental History:

Full term pregnancy? _____ Normal birth? _____

Any complications before, during, or following delivery? _____

Did your child crawl? _____ Age _____ Age at which child walked? _____

Age of speech: First words? _____ Sentences? _____

When fatigued, child will: Sag _____ Becomes irritable _____ excited _____

Under tension, is there any pattern of behavior, thumb-sucking, etc? _____

Pediatrician's name/address: _____

List any illnesses: _____ Age _____ Mild _____ Severe _____

Earaches _____

Present medications _____

Allergies: _____

Visual History:

How long has difficulty been noticed? _____

Previous visual examinations:

Reason for examination:	Doctor's Name	Date	Result

Members of family who have had visual attention and why:

Name	Age	Visual Situation

Give a brief description of your child as a person: _____

In order for us to keep costs down, payment is expected in full at the time of service. We will be more than happy to help you submit your insurance claims in order that you may be reimbursed.

Signature: _____ Date: _____