Freehold Eye & Vision Care
Carolyn LoBocchiaro, O.D.
1000 West Main Street
Freehold, NJ 07728
(732) 677-2710

Vision Therapy Evaluation History Form

Child's Full Name_____ Age____ Birth Date _____ M/F

School _____Grade ____

Teacher Name _____ Teacher Email_____

Who may we thank for referring you to our office? _____

Names of Legal Guardians_____

MEDICAL INFORMATION
(Please circle Y or N)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
Allergic/immunologic	Y/N	Other	Y/N		

Please explain _____

Last Physical Exam _____Doctor's Name_____

Medication Allergy Y/N To What? _____What happens? _____

Current Medication(s)_____

Have you had any Operations? Y/N Type? _____ When?_____

Cigarettes/Tobacco Y/N Alcohol frequent/occasional/never Other substances _____

Has a neurologic evaluation been performed? Y/N By whom? _____
When? _____ Results: _____
Has a psychological evaluation been performed? Y/N By whom? _____
When? _____ Results: _____

Does or did your child receive:
Occupational Therapy services? Y/N By whom? _____Reason(s)_____
When? _____
Physical Therapy services? Y/N By whom? _____Reason(s)_____
When? _____
Speech Therapy services? Y/N By whom? _____ Reason(s)_____
When? _____

FAMILY HISTORY
(please circle Y or N)

Glaucoma Y/N Relation _____ Macular Degeneration Y/N Relation _____
Cataracts Y/N Relation_____ Retinal Detachment Y/N Relation _____
Diabetes Y/N Relation_____ High Blood Pressure Y/N Relation _____
Eye Turn Y/N Relation_____ Amblyopia Y/N Relation_____
Other Eye Condition(s) Y/N Type _____ Relation _____

PERSONAL EYE INFORMATION
Last Eye Exam Date and Doctor's Name_____
Does your child wear glasses? Y/N Distance/Reading/Both
Blur at distance or near without glasses? Y/N
Blur while wearing glasses for distance? Y/N Blur while wearing glasses for reading? Y/N
Eye operation? Y/N Type _____ Date_____
Eye injury? Y/N Type _____Date_____
Glaucoma Y/N Cataracts Y/N Do your child's eyes Itch? Y/N Burn? Y/N Get Red? Y/N
Tear? Y/N Noticeable Eye Turn? Y/N
Television Viewing: How much? _____ Viewing Distance_____
Video Game Playing: How much? _____ Viewing Distance_____
Recreational Computer Use: How much? _____ Viewing Distance_____

DEVELOPMENTAL HISTORY
Full Term Pregnancy Y/N Normal Birth Y/N Explain_____ Birth weight_____
Age of first steps_____ Age of first words_____ Child's Dominant hand R/L

FAMILY & HOME
Please indicate which adults child lives with? Mother __Father __Stepmother __Stepfather__
Foster Parents __Grandmother __Grandfather __Aunt_ _Uncle __Other Caretaker__
Has your child been through a traumatic family situation (ex. divorce, parental illness) Y/N
Explain_____

Binocular & Visual Efficiency History

Complains of blurred vision	Y or N	Holds things very close	Y or N
Complains of blurred vision when looking near to far or far to near	Y or N	Loses place often	Y or N
Complains of headaches	Y or N	Complains of eyestrain	Y or N
Rubs eyes	Y or N	Must use finger to guide and keep place	Y or N
Inattentive	Y or N	Skips lines and words often	Y or N
Avoids reading	Y or N	Misreads parts of words	Y or N
Poor reading comprehension	Y or N	Covers or closes one eye when reading	Y or N
Is tired after reading	Y or N	Complains of double vision	Y or N
Slow worker	Y or N	Complains of words moving on the page	Y or N
All above negative	Y or N	Complains or words running together	Y or N

GENERAL BEHAVIOR

High activity level	Y or N
Poor attention span	Y or N
Impulsivity	Y or N
Frustrates easily	Y or N
Doesn't listen when spoken to	Y or N
Poor memory	Y or N
More active than other children his(her) age	Y or N
All above negative	Y or N

SIGNS OF VISUAL PROCESSING DISORDERS

Reverses letters and numbers	Y or N
Mistakes words with similar beginnings	Y or N
Can't recognize the same word repeated on the page	Y or N
Poor recall of visually presented materials	Y or N
Trouble with spelling	Y or N
Sloppy writing skills	Y or N
Erases Excessively	Y or N
All above negative	Y or N

ACADEMIC HISTORY

Age of entrance into kindergarten? _____ years_____ months
Does your child like school? Y/ N
Does your child like to read? Y/N Will read for fun Y/N Reading below, above, on grade level?_____
How are his(her) grades? Excellent, Good, Fair, Poor
Does your child spend a lot of time and effort to maintain this level of performance? Y/N
How much time on average does your child spend each day on homework assignments? _____
To what extent do you help your child with homework? _____
Does your child seem to be under extreme tension or pressure while doing schoolwork? Y/N
Do you feel your child is achieving up to potential? Y or N
Does the teacher feel your child is achieving up to potential? Y/N
Has a grade ever been repeated? Y/N If yes, which? _____
Current or past tutoring or specialized help? Y/N
Explain: _____
Please list any academic area(s) of difficulty _____

Signature

_____