



Deborah Zelinsky, O.D., F.C.O.V.D.
 Neuro-Optometrist
 www.mindeyeconnection.com

1414 Techy Road • Northbrook, Illinois 60062
 phone: 847-501-2020 • fax: 847-501-2021
 e-mail: mindeyeconnection@msn.com

B E Y O N D T R A D I T I O N A L V I S I O N C A R E

IMPORTANT: The information on this intake form will enable the doctor to ascertain and evaluate your child's needs most effectively. Please fill out the following as completely as possible and **PLAN 2 HOURS** for the initial examination. We look forward to meeting you!

INSTRUCTIONS: 1) Using your computer, you may type directly on this form. **PRINT A HARD COPY** in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form and write the information directly in the spaces provided. Fax or mail the completed form to the fax number or address in the upper right-hand corner. **PLEASE** forward any other pertinent records to our office after this form has been submitted.

I. Child's Information

Last name _____ First _____ Called by _____

Birth date Month Day Year Age Male Female

Street address _____

City _____ State _____ Zip _____

Home phone () _____

School _____ Grade _____

Favorite subjects _____ Least favorite subjects _____

Referred by? _____

II. Present Situation

Please describe the reason for this visual processing evaluation. (For instance, who first noticed the child's problem and when?)
 Type here:

Did the problem occur suddenly?
 Type here:

Do your child's problems seem to be related to illness, accident, or other trauma?
 Type here:

Ordinal position of child (i.e. 3rd of 6 = 3/6) _____ Number of household moves in child's lifetime? _____

| Academic problems: | None | Moderate | Severe |
|--------------------|--------------------------|--------------------------|--------------------------|
| Reading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spelling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Writing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arithmetic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Academic problems: | None | Moderate | Severe |
|--------------------|--------------------------|--------------------------|--------------------------|
| Science | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| History | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical education | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other, specify: What do you feel is the reason(s) for these problems?
 Type here:

II. Present Situation (continued)

Additional comments on problems in school or history? (Example: can't learn letters and sounds, always reverses letters)
Type here:

Regular attendance? Yes No

Did child ever repeat a grade? Yes No If yes, which?

Does child like school? Yes No

Teacher? Yes No Fellow students? Yes No

Has your child had any remedial work? Yes No When? _____

In what? _____ Effects? _____

Age of entrance into first grade _____ yrs. _____ months

| Organization: | Yes | Sometimes | No | | Yes | Sometimes | No |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|
| Fails to plan for homework | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trouble keeping on task | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does not finish attempted tasks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seeks excessive attention/help | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disorganized, messy work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Misjudges time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disorganized, messy room | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Misjudges space | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Play and Sports Activities: | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Does child have pet? | <input type="checkbox"/> | <input type="checkbox"/> | Participate in rhythm activities | <input type="checkbox"/> | <input type="checkbox"/> |
| Does child assume responsibility for pet? | <input type="checkbox"/> | <input type="checkbox"/> | (jump rope, dancing, patty cake, etc.) | | |
| Does child voluntarily use books & magazines? | <input type="checkbox"/> | <input type="checkbox"/> | Participate in ball activities | <input type="checkbox"/> | <input type="checkbox"/> |
| Does child like to be read to? | <input type="checkbox"/> | <input type="checkbox"/> | (baseball, basketball, etc.) | | |
| Does child hold book when being read to? | <input type="checkbox"/> | <input type="checkbox"/> | Does child like legos and puzzles | <input type="checkbox"/> | <input type="checkbox"/> |
| Listen to music? | <input type="checkbox"/> | <input type="checkbox"/> | Does child prefer indoor activities | <input type="checkbox"/> | <input type="checkbox"/> |

Motor Control:

Which hand does your child prefer for writing? Left Right Always? Yes No

Does your child have an awkward gait? yes No

Is your child clumsy? yes No

Is your child skillful with his/her hands? yes No

Foods:

Please list foods your child likes and foods that are avoided or disliked.

Likes

Type here:

Disliked or avoided

Type here:

III. Behavior Characteristics

| | Never | Sometimes | Often | | Never | Sometimes | Often |
|------------------------------------|--------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--------------------------|
| Awareness: | | | | "Know-it-all" attitude | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inattentive to what others say | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tense, uptight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Preoccupation in his/her own world | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Uncooperative | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Day-dreams | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Boisterous, rowdy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disoriented and confused | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impertinent, saucy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Short attention span | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to annoy others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distractable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity (always on the go) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Personality: | | | | Lacks enthusiasm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling of inferiority | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleeping / Activity: | | | |
| Easily led by others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restless while awake | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lacks self-confidence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Requires frequent naps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shy, bashful, easily embarrassed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restless during sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous, jittery, jumpy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty getting to sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxious (fearfulness) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does not get enough sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Needs large amount of sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specific fears _____ | | | | Extreme fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attitude: | | | | Awakens tired and slow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fighting, hot-tempered | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular arising time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Negative attitudes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating: | | | |
| Profane language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Finicky eater | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disruptive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular elimination habits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Destructive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eats large amount of sweets | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irresponsible - undependable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eats rapidly | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attention-seeking (shows off) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bites nails | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Additional comments:

Type here:

IV. Pregnancy and Delivery History

| During Pregnancy | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Was child active in utero? | <input type="checkbox"/> | <input type="checkbox"/> | Adequate and regular nutrition during pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood incompatibility (RH) | <input type="checkbox"/> | <input type="checkbox"/> | Toxemia (blood poisoning) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhage | <input type="checkbox"/> | <input type="checkbox"/> | Major illness or trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| Usage of internal medications during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic x-rays | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates? | <input type="checkbox"/> | <input type="checkbox"/> | Other abnormalities | <input type="checkbox"/> | <input type="checkbox"/> |
| Hallucinogenics? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, what? _____ | | |
| Excessive alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | Excessive smoking? | <input type="checkbox"/> | <input type="checkbox"/> |
| Labor - spontaneous with no complications? | <input type="checkbox"/> | <input type="checkbox"/> | Type of delivery: | Baby position at birth: | |
| If no, please explain | | | | | |
| Type Here: | | | | | |

IV. Pregnancy and Delivery History (continued)

Labor and Delivery:

| Length of Pregnancy (weeks) | Birth Weight | lbs. | oz. | Length | in. | |
|-----------------------------|--------------------------|--------------------------|-----------|-------------------------------|--------------------------|--------------------------|
| After Birth: | | Yes | No | | Yes | No |
| Blood exchange transfusion | <input type="checkbox"/> | <input type="checkbox"/> | | Severe Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Anoxia (lack of oxygen) | <input type="checkbox"/> | <input type="checkbox"/> | | Resuscitation | <input type="checkbox"/> | <input type="checkbox"/> |
| Incubator after birth | <input type="checkbox"/> | <input type="checkbox"/> | | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor sucking | <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal cry | <input type="checkbox"/> | <input type="checkbox"/> |
| Cord around neck | <input type="checkbox"/> | <input type="checkbox"/> | | Others, specify: _____ | | |

V. Child's Early Medical History

Past Illnesses:

| | Yes | No | Age | | Yes | No | Age |
|------------------------------|--------------------------|--------------------------|-------|---|--------------------------|--------------------------|-------|
| Head trauma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Convulsions or seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Reactions to drugs, vaccine allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetic | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Allergies - what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Severe ear infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hospitalization - If yes, for what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Serious infections or injury | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | | Frequent respiratory infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Broken bones? (Describe) | | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Are there any medications the child is taking frequently? If yes, for what purpose?
Type here:

VI. Development History

| Information obtained from: | Baby book <input type="checkbox"/> | Other records <input type="checkbox"/> | Memory <input type="checkbox"/> | |
|--|------------------------------------|--|---------------------------------|--------------------------|
| | Norm | Early | Average | Slow |
| Teething: | | | | |
| 2 lower central incisors | 6-9 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 upper lateral incisors | 8-12 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First permanent teeth | 5-6 Yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gross Motor: | | | | |
| Were there any problems in neck control development? | 4 mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting alone | 8 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawling alone | 9 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual crawl pattern (describe) _____ | | | | |
| Stand alone | 15 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk alone | 15 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fine Motor: | | | | |
| Elimination: bowel control | 12-24 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder control | 2-3 Yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing / buttoning clothes | 4 Yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lacing shoes | 5 Yrs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Emotional trauma? (loss of grandparent, pet, divorce, etc.) Describe: _____

Speech - Auditory History

| | Norm | Early | Average | Slow | Comments: |
|---|------------------------------|-----------------------------|---|--------------------------|-----------|
| Speech: Syllables | 6 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Da-da, etc. | 9 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2 words | 12 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4 words | 15 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Short sentences | 24 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gives full name | 30 Mo. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Was or is speech delayed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does child reply appropriately to simple directions and questions? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Is speech clear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does he ask for frequent repetitions of conversations or instructions? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Can child express his thoughts clearly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does he have to look at you to understand what you say? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Does child turn his head to one side to listen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is speech understandable by persons outside of family? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Does child often say "huh"? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does he/she repeat television commercials, jingles, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Does child omit of parts of words? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If given a list of things, can he/she bring back the correct items? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Does child "baby talk"? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Does child stutter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Is speech understandable by family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Is there a bilingual parent? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| What other language(s) are spoken at home? | | | | | |
| Type here: | | | | | |

Visual History

Has the child had any unusual visual attention or care? Yes No Describe: _____

Does child have glasses now? Yes No Does child wear them? Yes No

If yes, when should child wear them? _____

Have child's lenses been changed? Yes No How often? _____

| Does the child complain of: | Yes | Sometimes | No | Does the child: | Yes | Sometimes | No |
|------------------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reverse letters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision (far) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reverse words | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision (near) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skip or repeat words | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Keep place with finger | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye strain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Move lips | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bright lights | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Move head excessively | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lose place on page | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you noticed the child: | | | | Close or cover one eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rubbing eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tilt or turn head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Developing sties | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Distort face muscles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often blinking excessively | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have an awkward posture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Having red eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Maintain concentration for a long period of time? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting too close to the TV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Any other information? (example: When and how often do these symptoms occur?)

Type here:

VII. Previous Evaluations (i.e. speech and hearing, psychological, neurological)

Reason?

By whom

Date

Address

Reason?

By whom

Date

Address

Please request copies of all previous evaluation reports be sent to us prior to evaluation date to complete our history of your child.

VIII. Parent or Guardian Information

Father's [or Guardian] name

Mobile phone

Street address [if different from Child's]

City

State

Zip

Home phone

Work phone

E-mail

Occupation or position

Mother's [Guardian] name

Street address [if different from Child's]

City

State

Zip

Home phone

Work phone

E-Mail

Occupation or position

Signature

Date

We will ask you to sign this form at your first visit.

IMPORTANT: PRINT A HARD COPY in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form using the print menu. Fax or mail the completed form to the fax number or address in the upper right-hand corner on page one. PLEASE forward any other pertinent records to our office after this form has been submitted. Thank you!

A small photo is useful for our files. Please bring one with you to the examination OR insert a digital image. For successful e-mailing capacity It must be 150K or less @ 72dpi.

INSERT IMAGE HERE

SUBMIT