# Welcome to Our Practice

VISION ON KOORNANG
by Daniel & Clare

Please **download** this form, and then open in **Adobe Acrobat Reader** to fill out.
(If you don't have Acrobat, it is available for free **here.**)

**BEHAVIOURAL**

## 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 for Optical Extras? ..... Yes [ ] No [ ]
Private Health Fund Provider .....
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 [ ] Ophthamologist [ ] 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 headaches Yes [ ] 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 tired Yes [ ] No [ ]
Have head at an angle when reading Yes [ ] 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 reading Yes [ ] No [ ]
Complain of blurred vision when reading Yes [ ] No [ ]
Complain of eye strain Yes [ ] No [ ]
Complain of headaches Yes [ ] No [ ]
Have a short attention span when reading Yes [ ] No [ ]
Hold a book very close Yes [ ] 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 writing Yes [ ] No [ ]
Have difficulty following a series of instructions Yes [ ] No [ ]
Not recognise the same word repeated on a page Yes [ ] No [ ]
Have trouble learning left and right Yes [ ] No [ ]
Have untidy handwriting Yes [ ] No [ ]
Mistake words with similar beginnings Yes [ ] No [ ]
Have poor organisation on a page Yes [ ] No [ ]
Have poor reading comprehension Yes [ ] No [ ]
Have poor recall of visual material Yes [ ] No [ ]
Reverse letters and numbers Yes [ ] No [ ]
Seem to know material but does poorly on written material Yes [ ] No [ ]
Copy from the board to their book slowly Yes [ ] No [ ]
Have trouble learning letter/sound correspondence Yes [ ] No [ ]
Have trouble learning basic math Yes [ ] No [ ]
Have trouble with spelling and sight word vocabulary Yes [ ] No [ ]

## How did you hear about us?

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

Today's Date / /

Click to **Submit**

If the Submit function is ineffective, please save this form as a PDF and email to us at **info@visionok.com.au**

**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.