TENNESSEE
VISION THERAPY

Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.

Patient's Full Name:_____ Nickname:_____

Date of Birth:_____ Age: _____ Gender: Male or Female

Address:_____City:_____ Zip:_____

Cell:_____ Email:_____

Name of School:_____ Grade: _____

HOW DID YOU HEAR ABOUT US?

Referred: Name & Place of Business _____

Internet: Which terms did you search? Vision Therapy Lazy Eye Crossed Eye ADHD Learning Disabilities Convergence Autism Tracking Issues Reading Issues

Current/Previous Patient: _____

CONTACT INFORMATION

Mother/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

Father/Caretaker's Name: _____ Cell: _____

Email: _____ Work Phone: _____

Occupation & Place of Employment: _____

Your Child's Medical History: *Please fully complete*

Pediatrician: _____ Date of Last Visit: _____

Optometrist Name: _____ Date of last visit: _____

Current Medications (include vitamins/supplements): _____

_____

Is your child allergic to any medications or medical preservatives? **No Know Drug Allergies**

_____

Does the patient have a vitamin D deficiency? YES NO

Has the patient EVER had an allergic reaction to Atropine? YES NO

Does your child play sports, if so please list: _____

_____

At what age did the patient first start wearing eyeglasses or contact lenses? _____

What is your child's usual posture when reading (for example, sitting at a desk, in bed on their stomach, in bed on their back, etc?) _____

If your child is required to do a lot of reading (more than 10 minutes at once), when do they usually do it? Morning, afternoon, or night? _____

Parent History:

Currently wear eyeglasses or contact lenses? If yes, for what? _____

Any history of any eye surgery, including refractive surgery (LASIK, PRK, etc)?

_____

Age first wore eyeglasses or contact lenses, even if part time? _____

Any history Retinal holes, tears, detachments or degenerative myopia? _____

Sibling history questions:

NAME	Current Age	Male or Female	Glasses or Contacts	Started wearing @ age

SCREEN & LEISURE TIME

Average screen time per day (TV, tablets, computers, phones, etc.): _____

When your child is reading on a digital device (smartphone or computer), is the background black with white characters, or white with black characters? _____

During a typical day, how many hours per day does the patient spend outside? _____

SLEEP HABITS

How many hours of sleep does the patient get each night? _____

What time does you/your child usually go to bed? _____

How many nights per week does you/your child usually go to bed at approximately the same time? _____

Parent Signature: _____ Date: _____