INTAKE FORM - CHILD

Patient Information and Consent

Patient Information			
Name			
D.O.B.		School	
Parent or Guardian		Grade	
Address			
City		ZIP	
Phone		Email	

Vision History	**Yes**	**No**
1.) Is this your child's first eye examination?	○	○
2.) Does your child wear glasses?	○	○
3.) Does your child have an IEP?	○	●
4.) Does your child see a reading specalist?	○	●
5.) Does your child see a OT or PT?	○	●

What Concerns brought you in today?
1.)
2.)
3.)
4.)
5.)
6.)