(780) 757-2774
#206-8135, 102 St. Edmonton, AB
www.ImproveEyesightNaturally.ca

INTAKE FORM for Parents

Today's Date: **First Appt. Date & Time:**

Name of Child: Birthdate/Age:
Name of Parent/s/ Grandparent

Email:
Phone(s):
Address:

Who were you referred by? Or; how did you find out about Natural Vision Improvement Centre (NVIC)?

Vision history: Does your child wear glasses/contact lenses? If yes, how many hours/day does your child wear glasses/contacts?

Were there any challenges with your child's birth and early development (eg. breach or forceps delivery, fever or illness) ?

What was happening around the child during the 1-2 years prior to her/his needing glasses or developing vision issues? (e.g. Did the family move, was a new sibling born, illnesses, school difficulties etc?)

At what age did your child get their first pair of glasses/contacts? Age:

Has the eye doctor ever told you that even with lenses your child does not see 20/20? (yes/no)

Current prescription (if you don't know, ask an optometrist or optician to take your prescription from your current lenses): Complete the columns that apply to your prescription (often just the first column is necessary).

Prescription	Sphere/ Correction	Cylinder for Astigmatism	Axis for Astigmatism	ADD	Prism	Base
O.D. (Right Eye)						
O.S. (Left Eye)						

Estimate the Time (minutes/ hours a day spent:	Computer	Reading	Close up work	TV/Video Games	Outside in Natural Light

Do your child have any difficulty with night vision? (Yes/No):

Is she/he afraid of the dark?

Is he or she light sensitive? (Yes/No):

Does your child every complain of dry, itchy, red, irritated or tired eyes?

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Has your child experienced any kind of vision care or vision care or therapy besides glasses? If so, please describe:

How does he/she do with:

Reading?

Sports?

Riding in a car?

Does your child have difficulty with concentration, reading or spelling at school? Do they make simple mistakes or skip over words?

GENERAL HEALTH QUESTIONS:	Write your answers over here!
How well does your child sleep?	
Has your child ever been diagnosed as having an eye disease or complication?	
Is your child currently being treated for a medical problem? If so, please describe and list medications:	
What does s/he like to eat?	
Does your child seem well coordinated for his/her age?	
What activities or hobbies does your child enjoy most? Favourite toys, themes, books or shows?	

What are your goals for bringing your child to see me?

Is there anything else you'd like me to know about your child and/or your family?