PARENT'S NAME:_____ PATIENT'S NAME:_____

**PLEASE COMPLETE THIS FORM:**

In order to assist the doctor in evaluating all of your child's visual needs, please check the boxes that apply to your child:

- ☐ Honors Curriculum
- ☐ Regular Classroom
- ☐ Special Education
- ☐ Resource Room
- ☐ Speech/Language
- ☐ Occupational Therapy
- ☐ Repeated Grade _____
- ☐ Tutor for _____
- ☐ Title I Reading
- ☐ Other: _____

- ☐ Fast reader / average reader
- ☐ Slow reader
- ☐ Doesn't enjoy reading
- ☐ Prefers to be read to
- ☐ Poor reading comprehension
- ☐ Poor writing skills
- ☐ Homework takes longer than it should
- ☐ Smart in everything but school
- ☐ Short attention span
- ☐ Inconsistent or poor sports performance
- ☐ Fine or Gross Motor Skill Difficulties
- ☐ Fatigue, frustration, stress

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