Developmental History

Date _____

PERSONAL

Child's Full Name _____ Birthdate _____

Street Address _____ City, State, Zip _____

Telephone Number _____ Physician Name _____

School Name _____ Grade _____ Teachers Name _____

Spouse or Parents Name _____

Social Security # _____ Insurance _____ Whom do we thank for referral? _____

How did you learn about our office?   Phone Book ____   Friend or Family ____   Newspaper ____   Other ____

PRESENT SITUATION

Why do you feel your child needs a visual examination? _____

Is there any evidence from the school or psychological test that some visual difficulties may be present?   Yes ___   No ___

If so, please explain: _____

Does your child report any of the following?

Headaches? Yes ____ No ____ When? _____   Blurred Vision? Yes ____ No ____ When? _____

Double Vision? Yes ____ No ____ When? _____   Eyes Hurt / Tired? Yes ____ No ____ When? _____

List any other complaints your child has concerning his/her vision _____
_____

VISUAL HISTORY

Date of last visual exam _____ Doctor's Name _____

Reason for last exam _____

Were glasses prescribed? Yes ____ No ____   Are they worn? Yes ____ No ____ When? _____

Family vision conditions: Mother _____ Father _____ Siblings _____

Has your child ever received Vision Therapy? Yes ____ No ____ When? _____ Results? _____
_____

GENERAL BEHAVIOR

Are there any behavior problems at school? ____ At home? ____ Please describe _____

To what do you attribute these problems? _____
_____

SCHOOL

Age entering kindergarten? _____ First Grade _____ Does your child like school? Yes ____ No ____   Teacher? Yes ____ No ____ Do you feel that he / she is working up to potential?   Yes ____ No ____   Specifically describe any school difficulties
_____

Child's academic performance: **Reading** ----- Above Average ____ Average ____ Below Average____

Math-------- Above Average ____ Average ____ Below Average____

Spelling----- Above Average ____ Average ____ Below Average ____

Writing----- Above Average ____ Average ____ Below Average ____

Has grade been repeated? Yes ____ No ____ Which? _____

Does he / she seem to be under tension or extreme pressure when doing school work? Yes ____ No ____   Has he / she had any special

tutoring and / or remedial assistance? Yes ____ No ____ When? _____ From whom? _____ Where? _____

How Long? _____ Results? _____
_____

APPEARANCE OF EYES
____ One eye turned In or Out
____ Frequent blinking
____ Squinting or rubbing of the eyes
____ Frequent reddening or tearing of the eyes
____ Encrusted eyelids or frequent sty's

COMPLAINTS WHEN USING EYES FOR DESK WORK
____ Headaches
____ Eyes burning or watering after reading
____ Blur at far or near after or during reading

BEHAVIORAL SIGNS OF POSSIBLE VISUAL PROBLEMS
Eye movement abilities related
____ Loses place often during reading
____ Needs finger or book mark to keep place
____ Head turns as reading across page
____ Too frequently omits words
____ Rereads or skips lines unknowingly
____ Displays short attention span for reading and/or copying

Eye teaming abilities related (eye coordination)
____ Complains of seeing double, words run together
____ Repeats Letters within words
____ Misalign digits in number columns
____ Squints, closes, or covers one eye
____ Tilts head extremely while working
____ Consistently shows gross postural deviations while working at desk
____ Very slow reading speed

Focusing abilities related
____ Fatigues quickly while doing seat work
____ Displays short attention especially for desk work
____ Comprehension reduces as reading continues; Loses interest too quickly
____ Holds book very close; head too close to desk
____ Avoids all possible near-centered task
____ Laborious reading
____ Has good vocabulary but reading comprehension and retention are very low
____ Makes frequent errors in copying from the board or reference books
____ Squints to see the chalkboard, or request to move nearer

Visual perception abilities related
____ Mistakes words with similar beginnings
____ Reverses words, letters, or numbers
____ Confuses Likenesses and minor differences
____ Fails to visualize what is read
____ Whispers to self for reinforcement while reading silently
____ Returns to "drawing with fingers" to decide likes and differences and for counting

OTHER
____ Yearly evaluation
____ No problems, complaints
____ Blur at distance
____ Blur at near
____ Eyes hurt
____ SOI referral

DEVELOPMENTAL HISTORY
Full term pregnancy? _____ Normal birth? _____ Any complications before or after delivery? _____ Did your child

crawl? _____ All fours? _____ Was your child active? _____ Now? _____ List any severe illnesses your child has

had _____

Habits (thumb sucking, nail biting, etc.) _____

FAMILY AND HEALTH HISTORY
Briefly describe child's physical condition _____

Medication your child is currently using _____

For what condition (s)? _____

Did parents or any of the other children in the family have learning problems? Who? _____ To

what extent? _____

Nutrition
Please give a brief description of the nutritional philosophy in the child's home _____

_____

Personality
Please give a brief description of your child's personality _____

_____

As you complete this form you will recognize the thoroughness with which your child's visual problems will be considered. Your child's future deserves the fullest consideration that you, as a parent, and we, in the office, can provide.

It is often beneficial for us to discuss examination results with your child's school and/or other professionals involved in his / her care. Please sign below to authorize this exchange of information.

Signature _____ Date _____

Parent Name _____ Spouse _____

Home Telephone _____ Work Telephone _____