Developmental History

Personal Date:___________________

Child's Name:____Birthdate:___________________

Street Address____City/State___________________

School____Grade:____________________________

Teacher's name: ____Email:_____________________________________

Father's name: ______________________________________Occupation:______________________________________

Telephone_____________________________Email:____

Mother's name: _____________________________________Occupation:______________________________________

Telephone_____________________________Email:____

How did you hear about our office? (Who referred you?) ____

Present Situation

Why do you feel your child needs a developmental vision exam? ____

____

Is there any evidence from the school or psychological test that some visual difficulties may be present?

☐ Yes ☐ No Explain: ____

Pediatrician's Name: ____

Is your child generally healthy? ☐ Yes ☐ No Explain: ____

Medications currently used: ____

Diagnoses/Conditions: ____

Has your child been diagnosed on the autism spectrum? ☐ Yes ☐ No

Does your child have a seizure disorder? ☐ Yes ☐ No

Has your child been evaluated for: ☐ Neurological ☐ Psychological ☐ Occupational/speech/physical therapy

By Whom? ____

Results and Recommendations: ____

____

____

Visual History

Date of last vision exam:_________________ Doctor's name ______________________________________Reason for last exam: _

Were glasses prescribed? ☐ Yes ☐ No Are they worn? ☐ Yes ☐ No When? ______________

Family vision conditions:____

Has your child ever received vision therapy? ☐ Yes ☐ No If so, when? ______________________________

Results? ____

Does your child report any of the following?

☐ Headaches ☐ Blurred Vision ☐ Double Vision ☐ Eyes Hurt/Tired

☐ Other please describe: ____

Reason for today's visit? ____

Developmental History

Full term pregnancy? ☐ Yes ☐ No Normal Birth? ☐ Yes ☐ No

Did the mother experience any health problems during the pregnancy? ☐ Yes ☐ No Explain: _______________

Any complications before or after delivery? ____

Birth weight:__________Apgar scores:__________ Was your child active? ☐ Yes ☐ No Now? ☐ Yes ☐ No

Did your child crawl normally? ☐ Yes ☐ No For how long?______At what age did your child walk? _________

Did parents or any other children in the family have learning problems? ☐ Yes ☐ No

Explain: ____

School Performance

Age entering Kindergarten?_____1st grade? _____Does your child like school? ☐ Yes ☐ No Teacher? ☐ Yes ☐ No

Do you feel that your child is working up to potential? ☐ Yes ☐ No

Specifically describe any school difficulties: ____

____

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 a grade been repeated? ☐ Yes ☐ No Which grade? _____________

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

From whom?_________________How long?__________Results? ___________________________________

____

General Behavior

Are there any behavior problems at school? ☐ Yes ☐ No Describe:_______________________________________

____

At Home? ☐ Yes ☐ No Describe:____

Please give a brief description of your child's personality:

____
____
____
____

Does your child currently experience any of the following:	**If yes, when?**
_____ One eye turned in or out	
_____ Frequent blinking	
_____ Squinting or tearing of the eyes	
_____ Encrusted eyelids or frequent sties	
_____ Headaches	
_____Eyes burning or watering after reading	
_____ Blur at far or near after or during reading	
_____Loses place often during reading	
_____ Needs finger or book mark to keep place	
_____Head turns when reading across page	
_____Too frequently omits words	
_____Rereads or skips lines unknowingly	
_____Displays short attention span for reading and/or copying	
_____Complains of seeing double, words run together	
_____Repeat letters within words	
_____Misaligns 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	
_____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 tasks	
_____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	
_____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	
_____Blur at distance	
_____Blur at near	
_____Dizziness	
_____Double vision	
_____Slow at reading	
_____Poor at sports requiring eye/hand coordination	
_____Trouble with spelling	
_____Trouble judging distances	
_____Dislikes/avoids reading and writing	

A Consultation Report will be provided. Please list below the names, addresses and emails of the persons which you would like us to send reports. Examples of professionals that may benefit you sharing this report are teachers, physical, occupational and speech therapists, tutors, pediatricians, psychologists, psychiatrists, and other educational plans. We will not send out reports before you see the report and have your consultation.

Name:____Email: ____

Address:____Phone: ___________________________________

Name:____Email: ____

Address:____Phone: ___________________________________

Name:____Email: ____

Address:____Phone: ___________________________________

Name:____Email: ____

Address:____Phone: ___________________________________

I authorize the release of the consultation report to the above individuals:

Signature:____Date: ___________________________