



Developmental History

Personal

Date: _____

Child's Name: _____ Birthdate: _____

Street Address _____ City/State/Zip _____

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?
<input type="checkbox"/> One eye turned in or out	
<input type="checkbox"/> Frequent blinking	
<input type="checkbox"/> Squinting or tearing of the eyes	
<input type="checkbox"/> Encrusted eyelids or frequent sties	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Eyes burning or watering after reading	
<input type="checkbox"/> Blur at far or near after or during reading	
<input type="checkbox"/> Loses place often during reading	
<input type="checkbox"/> Needs finger or book mark to keep place	
<input type="checkbox"/> Head turns when reading across page	
<input type="checkbox"/> Too frequently omits words	
<input type="checkbox"/> Rereads or skips lines unknowingly	
<input type="checkbox"/> Displays short attention span for reading and/or copying	
<input type="checkbox"/> Complains of seeing double, words run together	
<input type="checkbox"/> Repeat letters within words	
<input type="checkbox"/> Misaligns digits in number columns	
<input type="checkbox"/> Squints, closes or covers one eye	
<input type="checkbox"/> Tilts head extremely while working	
<input type="checkbox"/> Consistently shows gross postural deviations while working at desk	
<input type="checkbox"/> Very slow reading speed	
<input type="checkbox"/> Fatigues quickly while doing seat work	
<input type="checkbox"/> Displays short attention especially for desk work	
<input type="checkbox"/> Comprehension reduces as reading continues	
<input type="checkbox"/> Loses interest too quickly	
<input type="checkbox"/> Holds book very close/head too close to desk	
<input type="checkbox"/> Avoids all possible near centered tasks	
<input type="checkbox"/> Laborious reading	
<input type="checkbox"/> Has good vocabulary but reading comprehension and retention are very low	
<input type="checkbox"/> Makes frequent errors in copying from the board or reference books	
<input type="checkbox"/> Squints to see the chalkboard, or request to move nearer	
<input type="checkbox"/> Mistakes words with similar beginnings	

<input type="checkbox"/> Reverses words, letters, or numbers	
<input type="checkbox"/> Confuses likenesses and minor differences	
<input type="checkbox"/> Fails to visualize what is read	
<input type="checkbox"/> Whispers to self for reinforcement while reading silently	
<input type="checkbox"/> Returns to "drawing with fingers" to decide likes and differences and for counting	
<input type="checkbox"/> Blur at distance	
<input type="checkbox"/> Blur at near	
<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Double vision	
<input type="checkbox"/> Slow at reading	
<input type="checkbox"/> Poor at sports requiring eye/hand coordination	
<input type="checkbox"/> Trouble with spelling	
<input type="checkbox"/> Trouble judging distances	
<input type="checkbox"/> 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, schools for IEP and other educational plans. We will not send out reports before you see the report and have your consultation.

Name: _____ Email: _____

Address: _____ Phone: _____

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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: _____