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CHILD'S HISTORY FORM

Child's Full Name: ______________________________ Nickname: ____________

Name of School: ______________________________ Grade: ____________

Teacher: ______________________________

PRESENT SITUATION

Who referred you to this office? ______________________________

Why do you think your child needs a visual examination?

____

Who first noticed the visual difficulty? ______________________________

When? ______________________________

Did this difficulty occur suddenly, or related to any specific illness, injury, or other occurrence?

____

DEVELOPMENTAL HISTORY

Were there any complications during pregnancy, delivery, or immediately after delivery?

____

Please indicate early, late or normal age

Milestone	Early	Normal Age	Late
Sat Without support			
Crawled			
Walked without assistance			
Spoke first words besides "Ma Ma, Da Da"			
Spoke in sentences			
Bowel Trained			
Bladder trained			
Rode bicycle without training wheels			
Began to read			
Began Tying shoes			

Was speech clear and adequate? __________ Is speech clear and adequate now? __________

GENERAL BEHAVIOR

Which hand does your child prefer for writing, eating, and in ball play?

Was handedness ever changed?

What activities are included in your child's usual play? ____________________

Is play active or quiet?

Is your child generally well coordinated?

If not, please describe: ____________________

Involved in sports?

Is your child good with hands for present age?

Are creations good representations of what your child names them to be?

Do puzzles, books, coloring, drawing, and similar activities hold your child's attention?

Can your child throw and catch a ball?

Does your child get along with other children/adults?

Is your child observant?

Is your child distractible?

Have you noted extreme or frequent fatigue?

Are there any tensional behaviors such as nail biting, tantrums, eye blinking, excessive rubbing, or rolling of the eyes? List: ____________________

Does your child need an unusual amount of sleep?

Does your child have frequent accidents, spills, or bumps into and trip over objects frequently? List: ____________________

Is there a history of injuries or accidents? ____________________

Involving the head? ____________________ Involving the eyes? ____________________

Are there any difficulties getting this child to eat a balanced, nutritious diet? If so, please describe:

____

SCHOOL

At what age did your child enter school? ____________________

Was any grade ever repeated?

*If yes, why? ____________________

School work? Better than average Average Below average

Is your child performing up to his/her potential?

*If not, what do you think is the problem ____________________

What is your child's best subject(s)? ____________________

Hardest? __________ Favorite? __________ Least Favorite? __________

Does your child like school? __________ Teacher? __________ Other children? __________

What does your child's teacher report about your child? ____________________

Has your child had any remedial work (when and in what subject)? ____________________

Is your child six months or more behind grade level in reading? YES NO

Is your child in any special classes/programs in school currently?

Where and why? ____________________

Does your child like to read?

Be read to?

How frequently does your child read or look at a book by his/her own motivation? ____________________

If your child is having difficulty reading, does it seem to be with learning sight words, phonetically sounding out words, fluidity and speed, sustaining close work activities?

FAMILY AND HOME:

Please indicate which adults he/she lives with:

Mother ____ Father ____ Step Mother ____ Step Father ____ Foster Parents ____ Adoptive Parents ____

Grandmother ____ Grandfather ____ Aunt ____ Uncle ____ Other: ______________________________

Has he/she ever been through a traumatic family situation? (such as divorce, parental loss, separation) _______

If yes, explain: ______________________ What Age: _____ Does he/she seem to have adjusted?

Is family life stable at this time? _______

How does he/she get along with...

parents?____

siblings? ____

Has there ever been any psychological, educational, audiological, neurological or other testing performed? __________

If yes give specifics: ____

Please bring a copy of the test results with you. This will help me understand what has been previously suggested.

VISUAL HISTORY AND CHECKLIST:

Has there been previous visual care? When and where?

____

Does your child have glasses/contact lenses? ______________________________________

At what age did they begin wearing glasses? ___________

Why and when are they to be worn? ______________________________________

Is there any history of an eye turning, lazy eye, eye disease, eye surgery, eye injury, vision therapy, or patching?

____

SYMPTOMS:

Headaches? If **YES** – Location of Headache: ____________________

Time of Onset ________________ How long do they last: ________________________

How long have they been occurring? __________________________

Double Vision? If yes, it is: Horizontal Vertical Diagonal

Does it occur at Distance or Near or Both? ___________________

Give a brief description of your child as a person:

Weighted Symptom Checklist

- After you consider each symptom, please circle the number that best describes your symptoms.
- **If** there has been a trauma, please note whether or not it was:
  Present before the accident (P), Worsened since the accident (W) or new since the accident (N).

Patient Name________________________ **Date**________________

Eye Teaming & Focusing Symptoms (Circle all that apply)

Symptom	Never	Seldom	Occasional	Frequently	Always	P/W/N
Head tilt/ eye closure or cover/ face turn when reading or viewing objects	0	1	2	3	4	
Eyestrain, eye pain, trouble moving eyes, ocular fatigue, rubbing of eyes	0	1	2	3	4	
Eye drift: Left eye Right Eye Inward Outward	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Words appear to run together when reading; words move on the page	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Difficulty copying from the board or taking notes	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Avoidance of or discomfort with near vision work such as reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Car and motion sickness	0	1	2	3	4	
Does not judge distances accurately (difficulty with stairs/catching a ball)	0	1	2	3	4	
Holds books too close or leans to close to computer screen	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Poor hand/eye coordination	0	1	2	3	4	
Unable to maintain eye contact or steady fixation	0	1	2	3	4	
Blurred vision: Near Distance	0	1	2	3	4	
Blurred vision is worse at the end of the day	0	1	2	3	4	
Complains of blurred vision when looking/refocusing from near to far	0	1	2	3	4	
Light sensitivity	0	1	2	3	4	

TOTAL: _______/88

Tracking Symptoms

Symptom	Never	Seldom	Occasional	Frequently	Always	P/W/N
Reading comprehension is low or declines as day wears on	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Omits small words while reading	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Substitutes words while reading or copying	0	1	2	3	4	
Head/body movements while reading	0	1	2	3	4	
Fills in the wrong bubbles on computer graded tests	0	1	2	3	4	
Loses place when reading	0	1	2	3	4	

TOTAL: _______/36

Visual Processing Symptoms

Symptom	Never	Seldom	Occasional	Frequently	Always	P/W/N
Slow word to word reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
Confuses similar words	0	1	2	3	4	
Can't recognize the same word repeated on a page	0	1	2	3	4	
Trouble with spelling and/or sight vocabulary	0	1	2	3	4	
Trouble learning left from right	0	1	2	3	4	
Reverses letters and numbers	0	1	2	3	4	
Poor spacing when writing; writes up or down hill	0	1	2	3	4	
Awkward posture or pencil grip when writing	0	1	2	3	4	
Seems to know material but does poorly on written tests	0	1	2	3	4	
Poor recall of visually presented material	0	1	2	3	4	

TOTAL: _______/44 (168)

TOTAL: ________

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. I am looking forward to meeting your child and helping your child meet their visual needs.

Dr. Don Blackburn is a participating provider for most insurance companies. However, if he is not a provider of your insurance company, payment is expected at the time of service. We will gladly give you the appropriate information for you to submit to your insurance if you would like reimbursement. You may need to contact your insurance company to inquire about what you will need for reimbursement. This may include a referral from your family doctor. I have enclosed information regarding how to determine if your insurance company will cover vision therapy or a consultation regarding a vision therapy evaluation. If you have any questions regarding your insurance coverage of vision therapy, please contact your insurance company.

In order for us to keep cost down, payment is expected in full at time of service. Additional testing of visual processing skills may be required. The testing is $280.00 for two hours. The cost is prorated based on the amount of time spent. Typically, testing lasts approximately hour. By signing below you understand that you may have to submit to your insurance for reimbursement. You understand that YOU ARE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY YOUR INSURANCE.

Signature: ______________________________ Date: ________________