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DELAWARE VISION ACADEMY

Developmental Optometry

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YOUNG ADULT 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?
_____
_____

SCHOOL

At what age did your child enter school? _____
Was any grade ever repeated? Yes No
*If yes, why? _____
School work? ☐ Better than average ☐ Average ☐ Below average
Is your child performing up to his/her potential? Yes No
*If not, what do you think is the problem _____
Is your child six months or more behind grade level in reading? Yes No
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 in any special classes/programs in school currently? Yes No
Where and why? _____
Does your child like to read? Yes No
Be read to? Yes No
How frequently does your child read or look at a book by their 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, or a combination of these? ***Please Circle All That Apply***

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)

Y N What Age: _____ Does he seem to have adjusted? Y N

Is family life stable at this time? Y N

How does he/she get along with...

parents? _____

siblings? _____

Has there ever been any psychological, educational, audiological, neurological or other testing performed? Yes No

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? **Yes** **No** If **YES** – Location of Headache: _____

Time of Onset _____ How long do they last: _____

How long have they been occurring? _____

Double Vision? **Y** **N** If yes, is it 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)

	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

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

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)

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 $140 for the hour. Cost is prorated if testing does not last one full 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: _____