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DELAWARE VISION ACADEMY

Developmental Optometry

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Young Child History Form

Child's Full Name _____ Nickname _____
Name of Pre-School or Daycare Facility _____
Teacher _____

PRESENT SITUATION:
Who referred you to this office? _____
Is your child especially afraid of doctors?
Why do you think your child needs a vision exam? _____
_____
Who first noticed the visual difficulty? _____
When? _____
Did this difficulty occur suddenly, or related to any specific illness, injury or other occurrence?
_____
Is there any evidence from another professional that some visual malfunction may be present?
If so, please describe: _____

MEDICAL HISTORY
Is your child diagnosed as having:

ADD OR ADHD	DEVELOPMENTAL DELAY
ASPERGER'S SYNDROME	LEARNING DISABILITIES
AUTISM	SENSORY INTEGRATION DISORDER
CERBRAL PALSY	SEIZURE DISORDER

OTHER PROBLEMS: _____
List illnesses, bad falls, head injuries, eye injuries, high fevers, etc

Are there any chronic conditions like asthma, hay fever, allergies, etc? If so, please list:
_____
Has a neurological evaluation been scheduled?
By whom? _____
Results: _____

DEVELOPMENTAL HISTORY

Were there any complications during pregnancy, delivery, or immediately after delivery?
Full term pregnancy? Normal birth? _____
Did your child crawl (stomach on the floor)?
Did your child creep (stomach off floor)?
Did your child move on all fours? Age: _____ If not describe: _____

Please indicate early, late or normal age:

Milestone	Early	Normal	Late
Sat without support			
Crawled			
Age 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: Moderately Active Extremely Active	
Are there periods of time of high energy? _____ Low energy? _____	
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?	
Are there any difficulties getting this child to eat a balanced, nutritious diet?	
If so, please describe:	

Does your child receive:

Occupational therapy services By whom? _____

Results: _____

Physical therapy services By whom? _____

Results: _____

Speech therapy services By whom? _____

Results: _____

Other therapy services By whom? _____

Results: _____

Has there ever been any psychological, educational, audiological, neurological or other testing performed? _____ If yes, please have a copy of the testing results with you as this will help me understand what has been suggested previously.

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 a lazy eye, eye disease, eye surgery, eye injury, vision therapy, or patching?

_____

SIGNS/SYMPTOMS

Does your child report any of the following:

Headaches? If YES – Location of Head: _____

Time of Onset _____ How long they last _____

How long have they been occurring? _____

Any history of crossed eyes (strabismus)? If yes, eyes turn: ____ Out ____ In ____ Diagonal

Does it occur at distance, near or both? _____

Blurred vision? When: _____

Double Vision? When: _____

Eyes hurt/tired? When: _____

List any other complaints your child makes concerning his/her vision:

_____

Have you ever noticed the following:

Eyes frequently reddened? When: _____

Frequent eye rubbing? When: _____

Frequent blinking? When: _____

Closing or covering one eye? When: _____

Knock things over off of tables or desks frequently?

SENSORIMOTOR DEVELOPMENT

Please select **YES** or **NO** for each question, then, check ☑ next to each of the subsequent statements that describes your child. Your responses will probably be most accurate if you ***read all of the descriptions under the question prior to selecting "yes" or "no"***. If you have additional or different descriptions, please include them under **"other"**.

1. Is your child particularly sensitive to touch? _____

____ did not always find touch to be calming or pleasurable as an infant
____ is more annoyed than other children the same age by having a shampoo or face wash
____ is very picky about textures or clothing
____ is very fussy about the clothing
(E.g. dislikes collars; dislikes having to button the top button of a shirt; is uncomfortable in hats, etc.)
____ is uncomfortable with long sleeves and pants; prefers as little clothing as possible
____ prefers long sleeves and pants, even in warm weather
____ avoids messy activities, such as play dough, clay, mud pies, finger paints, and cooking
____ is excessively ticklish
____ overreacts to physically painful experiences
____ under-reacts to physically painful experiences
____ tends to withdraw from a group, or bump or push others in a group, is irritable in close quarters
OTHER: _____

2. Does your child have trouble with gross motor or posture? _____

____ tends to slump in chair or sprawl over chair and table
____ does not feel very "firm" when you lift child up or move child's limbs to dress
____ has difficulty turning knobs or handles which require some pressure
____ fatigues easily during family outings or during physical activities
____ has a loose grasp on objects, such as pencil, scissors, spoon or something he/she is carrying
____ has a rather tight, tense grasp on objects or pencils.
OTHER: _____

3. Does your child particularly enjoy fast moving or spinning equipment at the playground or at home, seeming to be less dizzy than others or not dizzy at all? _____

____ likes to swing very high and/or for a long time
____ frequently rides the playground merry-go-round when others help keep it turning
____ especially likes movement at home, bouncing on furniture, rocking chair, or swiveling chair
____ enjoys getting upside-down position (feet up, head down)
____ likes games where vision is occluded, keeping eyes closed for fun or using a blindfold
____ enjoys most of the fast and "scary" kiddy rides when at an amusement park
OTHER: _____

4. Does your child show excessive caution in approaching activities involving fast movement or movement of the body in space? _____

____ tends to avoid swings or slides or uses them with hesitation
____ does not like tiding a see-saw or going up and down an escalator
____ is cautious about heights and climbing
____ enjoys movement initiated by himself/herself but not by others, especially if it's unexpected
____ dislikes trying new movement activities or has difficulty learning them
____ has difficulty climbing or descending stairs or hills
____ tends to get motion sickness in a car, airplane, or elevator
OTHER: _____

5. Does your child have difficulty orienting his/her body effectively for dressing activities, such as putting arms in sleeves, putting fingers in mittens or putting toes in socks? _____
Comments: _____

6. Does your child avoid engaging in active physical games involving running, jumping, and using large play equipment? _____
Comments: _____

7. Does your child avoid seeking out activities requiring manipulation of small objects? _____
Comments: _____

8. Does your child avoid activities involving the use of tools such as crayons, markers, scissors, etc? _____
Comments: _____

9. Have you ever had concerns regarding your child's speech and language skills? _____
Comments: _____

10. Have you ever had concerns regarding your child's hearing, either in general or in conjunction with ear infections? _____
Comments: _____

11. Is your child particularly sensitive to noise (e.g. puts hands over ears when others are not bothered by sounds)? _____
Comments: _____

12. Do you feel that your child lacks an adequate attention span for things which he/she enjoys? _____
Comments: _____

13. Do you feel that your child tends to be restless or "fidgety" during times when quiet concentration is required? _____
Comments: _____

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? _____
If yes, what age: ___ Does he/her seem to have adjusted? _____ Is family life stable at this time? _____
How does he/she get along with parents?
_____
Siblings? _____
Playmates at home? _____

Give a brief description of your child as a person:

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 at this time. However, we do not accept assignment for those insurances that he is not a provider and payment is expected at the time of service. We will gladly give you the appropriate information necessary for you to get reimbursed from your insurance company. You may need to contact your insurance company regarding what you may need to get reimbursed such as a referral from your family doctor. If you have any questions regarding your insurance coverage of vision therapy, please contact your insurance company. Enclosed is a form with questions that you should ask your insurance company to determine what coverage you have.

In order for us to keep cost down, payment is expected in full at time of service. I understand that I may have to submit to my insurance for reimbursement. I understand that I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Signature: _____ Date: _____

Would you like any copies of any reports sent anywhere? If so, please list:

_____

Please sign below to give us permission to release information about your child to the above sources.

Signature: _____ Date: _____