wow vision therapy

YOUNG CHILD HISTORY

Developmental Vision & Rehabilitation

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Date

General Information

Child's full name_____
Age _____Birthdate _____
Referred by _____
Is your child especially afraid of doctors? _____

Family Information

Father _____Birth Date _____
Mother_____Birth Date _____
Brothers Birth Date

_____

_____

Sisters Birth Date

_____

_____

Parent Information

Home Address _____
City_____
State _____ Zip_____
Home phone_____
Cell phone _____
Fax number _____
e-mail_____
Father's occupation _____
Employer_____
Work phone _____
Mother's occupation _____
Employer_____
Work phone _____
Do you have a health care plan? _____
Name of the health care plan_____
Policy number_____

Medical history

Most recent medical examination
Doctor's name _____
Date_____
Results _____
Medications currently using _____
For what condition _____

Any history in your family of the following?

☐ Glaucoma ☐ High Blood Pressure

Has you child been diagnosed as having:

☐ Learning Disabilities ☐ Developmental Delays
☐ Add Or Adhd ☐ Cerebral Palsy
☐ Seizure Disorders ☐ Autism
☐ Other Problems

List illnesses, bad falls, head injuries, high fevers, etc.

_____

_____

Concussions? _____
When?_____
Complications and ages_____

_____

_____

Is your child generally healthy?_____
Are there chronic problems like Asthma, Hay Fever, Allergies, Ear Infections? _____
If so, please list _____

_____

_____

Has a neurological evaluation been performed? ____

_____

By whom_____
Results _____

Does Your Child Currently Receive

Occupational therapy services? _____
By whom_____
Results _____
Frequency_____
Physical therapy services? _____
By whom_____
Results _____
Frequency_____
Speech therapy services?_____
By whom_____
Results _____
Frequency_____
Other therapy services?_____
By whom_____
Results _____
Frequency_____

Nutritional Information

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Does your child crave sweets? _____
Is your child: ☐ Moderately active ☐ Extremely active
Are there periods of very high energy? _____
Low energy? _____
Has your child had any allergy testing? _____
When?_____
By whom? _____
Results:_____
_____
_____
Does your child have any food sensitivities?_____
Does your child take any vitamins or supplements? _____

Developmental History

Full term pregnancy? _____
Normal birth? _____
Birth weight _____
Any complications before, during or immediately following birth? _____
_____
Did your child crawl (stomach on floor)? _____
Age _____
Did your child creep (stomach on floor)? _____
Age _____
Did your child move on all fours? _____
Age _____
If not, describe _____
_____
At what age did your child walk? _____
Was child active? _____

Developmental History cont.

First words at age: _____
Was early speech clear to others?_____
Is it clear now? _____
Any history of crossing eyes? _____
What age first noticed?_____
Any family history of crossing eyes?_____
Who? _____

Visual History

Doctor's name _____
Date_____
Reason for examination_____
Results _____
Were glasses prescribed? _____
Are they worn?_____
When?_____
Members of the family who have had visual attention and why?

Name_____Age _____
Why _____
Name_____Age _____
Why _____

Present Situation

Is there evidence from school or psychological tests that some visual malfunction may be present?
If so, what?_____

Does Your Child Report Any of the Following

Headaches _____
when? _____
Blurred vision _____
when? _____
Double vision_____
when? _____
Eyes "hurt or tired" _____
when? _____
List any other complaints your child makes concerning his/her vision _____
_____

Have You Ever Noticed the Following

Eyes frequently reddened_____
If so, when? _____
Frequent eye rubbing_____
If so, when? _____
Frequent blinking _____
If so, when? _____
Closing of covering one eye _____
If so, when? _____

For each question, please check "yes" or "no" and then check each of the subsequent statements which describe your child. Your responses will probably be most accurate if you read all the descriptions under the question before selecting "yes" or "no." If you have additional or different descriptions, please include them under "other."

1. Is your child sensitive to touch? ☐ Yes ☐ No

- ☐ Did not always find touch to be calming or pleasurable as an infant
- ☐ Is more annoyed than other children the same age by having shampoo or face washed
- ☐ Is very picky about textures and 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 in long sleeves and pants, prefers as little clothing as possible
- ☐ Prefers long sleeves and pants, even in warm weather
- ☐ Avoids messy activities such as playdough, clay, mudpies, fingerpaints 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 punch others in a group, is irritable in close quarters.
- ☐ Other _____

2. Does your child have trouble with gross motor or posture? ☐ Yes ☐ No

- ☐ Tends to slump in the 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 a pencil, scissors, spoon or something he/she is carrying
- ☐ Has a rather tight, tense grasp on objects
- ☐ 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?

☐ Yes ☐ No

- ☐ Likes to swing very high and/or for a long time
- ☐ Frequently rides the playground merry-go-round when others help to keep it turning
- ☐ Especially likes movement at home, bouncing on furniture, rocking chair or swivelling chair
- ☐ Enjoys getting into an upside-down position (feet up, head down)
- ☐ Likes games when vision is occluded, keeping eyes closed for fun or using a blindfold
- ☐ Enjoys most of the fast and "scary" kiddie rides when at an amusement park
- ☐ Other _____

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

☐ Yes ☐ No

- ☐ Tends to avoid swings or slides or uses them with hesitation
- ☐ Does not like riding a see-saw or going up and down an escalator
- ☐ 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. Do you feel your child has already established a definite hand preference or dominance?

☐ Prefers the right hand ☐ Prefers the left hand

Comments_____

6. Can your child easily orient his/her body effectively for dressing activities, such as putting arms in sleeves, putting fingers in mittens or putting toes in socks?

☐ Yes ☐ No

Comments _____

7. Does your child spontaneously engage in active physical games involving running, jumping and use of large play equipment?

☐ Yes ☐ No

Comments _____

8. Does your child spontaneously seek out activities requiring manipulation of small objects?

☐ Yes ☐ No

Comments _____

9. Does your child spontaneously choose to do activities involving the use of "tools" such as crayons, pencils, markers, scissors, etc?

☐ Yes ☐ No

Comments _____

10. Have you ever had concerns regarding your child's speech and language skills?

☐ Yes ☐ No

Comments _____

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

☐ Yes ☐ No

Comments _____

12. Is your child particularly sensitive to noise (for example, puts hands over ears when others are not bothered by sounds)?

☐ Yes ☐ No

Comments _____

13. Do you feel that your child has an adequate attention span for things which he/she enjoys?

☐ Yes ☐ No

Comments _____

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

☐ Yes ☐ No

Comments _____

General Behavior

Are there any behavior problems? ☐ Yes ☐ No

What causes these problems?

_____

_____

Family and Home

Please indicate which adults he/she lives with:

☐ Mother ☐ Father
☐ Step mother ☐ Step father
☐ Foster parents ☐ Adopted parents
☐ Grandmother ☐ Grandfather
☐ Aunt ☐ Uncle
☐ Other

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

_____

What age was he/she? _____

Does he/she seem to have adjusted?

☐ Yes ☐ No

Is family life stable at this time?

☐ Yes ☐ No

How does he/she get along with parents? _____

_____

Siblings? _____

_____

Playmates at home?_____

_____