wow vision therapy

SCHOOL AGE CHILD HISTORY

Developmental Vision & Rehabilitation

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Date

General Information

Child's Full Name _____
Age _____Birthdate _____
School _____
School Address _____
Grade_____Teacher _____
Principal _____Referred by _____
Is your child especially afraid of doctors? _____

Family Information

Father _____
Birthdate _____
Mother _____
Birthdate _____
Brothers: Birthdates:
_____
_____
Sisters: Birthdates:
_____
_____

Parent Information

Home address _____
City _____ State_____Zip_____
Home phone _____
Cell phone _____
Fax number _____
Email _____
Father's occupation _____
Employer _____
Work phone _____
Mother's occupation _____
Employer _____
Work phone _____
Do you have a health care plan? _____
If so, name of 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 your 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 & ages:
_____
_____
Is your child generally healthy? _____
Are there any chronic problems like asthma, hay fever, allergies, ear infections? _____
If so, please list: _____
_____
_____
Has a neurological evaluation been performed? ____
By whom? _____
Results: _____
_____
Has a psychological evaluation been performed? __
By whom? _____
Results: _____

Does your child currently 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:_____
_____

Nutrition

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 delivery?_____
Did your child crawl (stomach on floor)?_____
Age: _____
Did your child creep (stomach off 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 (continued)

Speech: First words at age:_____
Was early speech clear to others?_____
Is it clear now? _____
Any history of crossing eyes? ☐ Yes ☐ No
What age first noticed: _____
Any family history of crossing eyes? ☐ Yes ☐ No
Who? _____

Visual History

Previous Eye Examination:
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	Visual Situation

Present Situation

Is there any 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: ☐ Yes ☐ No
When?_____
Blurred vision: ☐ Yes ☐ No
When?_____
Double vision: ☐ Yes ☐ No
When?_____
Eyes "hurt or tired": ☐ Yes ☐ No
When?_____
List any other complaints your child makes concerning his/her vision: _____
_____
_____
_____
_____

Have you ever noticed the following:

Eyes frequently reddened Yes☐ No☐
If so, when?_____

Frequent eye rubbing Yes☐ No☐
If so, when?_____

Frequent blinking Yes☐ No☐
If so, when?_____

Closing or covering one eye Yes☐ No☐
If so, when?_____

Head close to paper
when readingor writing: Yes☐ No☐

Tilting head when reading: Yes☐ No☐

Tilting head when writing: Yes☐ No☐

Confuses letters or words: Yes☐ No☐

Reverses letters or words: Yes☐ No☐

Skips, rereads or omits words: Yes☐ No☐

Vocalizes when reading silently: Yes☐ No☐

Reads slowly: Yes☐ No☐

Uses finger as a marker: Yes☐ No☐

Poor reading comprehension: Yes☐ No☐

Writes or prints poorly: Yes☐ No☐

Tires easily: Yes☐ No☐

Avoids near tasks: Yes☐ No☐

Short attention span: Yes☐ No☐

Poor motor coordination: Yes☐ No☐

Difficulty catching/hitting a ball: Yes☐ No☐

Television viewing: How much

How often _____

Viewing distance_____

_____

School

Age at time of entrance to kindergarten _____

First grade_____

Does child like school? Yes☐ No☐

Teacher? Yes☐ No☐

School work is: _____ Above average

_____ Average

_____ Below average

Do you feel he/she is working up to potential? ____

_____

Does teacher feel he/she is working up to potential?

What school subjects come easy for child? _____

_____

Does child like to read? Yes☐ No☐

Voluntarily? Yes☐ No☐

What? _____

_____

Specifically describe any school difficulties: _____

_____

_____

_____

Has a grade been repeated? Yes☐ No☐

Which? _____

Has he/she changed schools often?_____

_____

When?_____

Does he/she seem to be under tension or extreme pressure when doing schoolwork?_____

_____

Has he/she had any special tutoring and/or remedial assistance? Yes☐ No☐

When?_____

From whom? _____

Where? _____

How long? _____

Results:_____

How well developed is his/her spoken vocabulary?

_____

What is the child's attitude toward reading, school, his/her teacher, other youngsters?_____

_____

_____

General Behavior

Are there any behavior problems_____
School: _____ Home: _____
What causes these problems?
_____
_____
_____

Child's reaction to fatigue:
Sad_____
Irritable _____
Other_____

Child's reaction to tension?
Nail biting_____
Thumb sucking _____
Other_____

Does he/she say and/or do things impulsively? Yes☐ No☐
In constant motion Yes☐ No☐
Can't sit still for long periods? Yes☐ No☐

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) Yes☐ No☐
What age was he/she?_____
Does he/she seem to have adjusted?_____
Is family life stable at this time? Yes☐ No☐

Family and Home

How does he/she get along with parents? _____
_____
_____
Siblings? _____
_____
_____
_____
Classmates at school? _____
Playmates at home? _____
Did father or anyone in father's family have a learning problem? Yes☐ No☐
Who? _____
_____
_____
Did mother or anyone in mother's family have a learning problem? Yes☐ No☐
Who? _____
_____
_____

Is there any history of cognitive impairment, psychological diagnosis, etc., on either side of the family? Yes☐ No☐
Who? _____
Do any, or did any of the other children in the family have learning problems? Yes☐ No☐
Who? _____
To what extent? _____
_____
_____
_____

Give a brief description of your child as a person:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____