YOUNG ADULT HISTORY

Developmental Vision & Rehabilitation

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| Name | Date |
|---|---|

Referred by ____________________

## General Information

Home Phone ____________________ Cell Phone ____________________
Fax Number ____________________ E-Mail ____________________
Home Address ____________________
City ____________________ State ______ Zip ____________________
Social Security Number ____________________ Age ____________________
Birth Date ____________________ Sex *M* *F*
Emergency Contact ____________________
Name of Health Care Plan? ____________________
Policy Number ____________________

## 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 ____________________

## Visual History

Doctor's name & date ____________________

Results ____________________

Were glasses prescribed? ____________ Are they worn? ____________

When? ____________ Any history of crossing eyes? ____________

What age first noticed? ____________ Any family history of crossing eyes? ____________

Who? ____________________

## Other Evaluations

Has a neurological evaluation been performed? ______ By whom? ____________

Results: ____________________

Has a psychological evaluation been performed? ______ By whom? ____________

Results: ____________________

List any other complaints concerning your vision: ____________________

____________________

## Health Information

Medications currently taking ____________________

For what condition? ____________________

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

____________________

Concussions & when:

____________________

## Present Situation

Is there any evidence from school or psychological tests that some visual malfunction may be present? ______

____________________

____________________

____________________

If so, what? ____________________

____________________

____________________

____________________

____________________

## Do you 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: ____________________
____________________
____________________

## Vision Health History

Members of the family who have had visual dysfunctions and why:

| Name | Age | Visual Situation |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

Any history of the following, please check:

| | You | Family | | You | Family |
| --- | --- | --- | --- | --- | --- |
| High Blood Pressure | | | Headaches/Migraines | | |
| Eye Turn/Strabismus | | | Sinus Problems | | |
| Diabetes | | | Lazy Eye/Amblyopia | | |
| Double-Vision | | | Allergies | | |
| Retinal Disease | | | Color Deficiency | | |
| Learning Problems | | | Glaucoma | | |

## 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 |

## School

Specifically describe any school difficulties: _______

______________________________________

______________________________________

______________________________________

Has a grade been repeated? Yes No

When?__________________________________

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

When?__________________________________

From whom? _____________________________

Where? _________________________________

How long? ______________________________

Results:_________________________________