



YOUNG CHILD HISTORY

Developmental Vision & Rehabilitation

Dan L. Fortenbacher, O.D., FCOVD

Alyssa L. Bartolini, O.D., FCOVD

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 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 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 or 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 _____

General Behavior

Are there any behavior problems? Yes No

What causes these problems?

Family and Home

Please indicate which adults he/she lives with:

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Step mother | <input type="checkbox"/> Step father |
| <input type="checkbox"/> Foster parents | <input type="checkbox"/> Adopted parents |
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Aunt | <input type="checkbox"/> Uncle |
| <input type="checkbox"/> 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? _____

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 _____