Vision Therapy Centers, SC

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Please bring this form to your child's appointment. This assists us in determining the visual performance tests needed. If your child has an Individual Education Plan (IEP), or other testing which we should be aware of, please provide a copy.

School Age Child History (4-21 years)

Date_____ Completed By_____

How did you learn about A B See?_____

_____

General Information

Child's name

_____
(LAST) (FIRST) (M)

Birth Date_____ Age_____ Grade ___ Gender F M

Home Address_____

City_____ State_____ Zip_____

Name of Health Care Plan_____

Policy Holder_____

Policy number_____ Group#_____

Medical Billing Address_____

_____

Pediatrician_____

Pediatrician's phone number_____

Parent Information

Father's name

_____
(LAST) (FIRST) (M)

Home Address_____

City_____ State_____ Zip_____

Home phone___(____)_____

Cell phone____(____)_____

E-mail_____

Father's occupation_____

Employer_____

Work phone___(____)_____

May we contact you at your business? ☐ Yes ☐ No

Mother's Name

_____
(LAST) (FIRST) (M)

Home Address_____

City_____ State_____ Zip_____

Home phone___(____)_____

Cell phone____(____)_____

E-mail_____

Mother's occupation_____

Employer_____

Work phone___(____)_____

May we contact you at your business? ☐ Yes ☐ No

Responsible party_____

Phone_____(____)_____

Medical History

Most recent medical examination:

Date:_____

Doctor's name:_____

Results:_____

Current Medications: Taken For:

Is your child generally healthy?_____

Are there any chronic problems like asthma, hay fever or allergies?_____

If so, please list:_____

_____

_____

_____

Has a neurological evaluation been performed?_____

By whom?_____

Results:_____

_____

Has a psychological evaluation been performed?_____

By whom?_____

Results:_____

_____

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 fever, surgeries etc._____

_____

_____

Complications and ages:_____

_____

_____

_____

_____

Medical History continued

Please check any of the following which your child has or has had in the past:

Allergies/ Immunology
_____Drug Allergies
_____Environmental Allergy
_____Rheumatoid Arthritis
_____Lupus
_____Other
List all allergies:

Integumentary
_____Eczema
_____Rosaces
_____Psoriasis
_____Ring Worm
_____Other
Explain:

Constitutional
_____General Good Health
_____Recent Weight Change
_____Fever
_____Fatigue
_____Developmental Disability
_____Other
Explain:

Hematological/ Lymphatic
_____Anemia
_____Bleeder
_____Slow to heal after cut
_____Leukemia
_____Large volume blood loss
_____Enlarged glands
_____Blood transfusions
_____Other
Explain:

Respiratory
_____Allergies
_____Cigarette Smoker
_____Asthma
_____Bronchitis
_____Other
Explain:

Gastrointestinal
_____Loss of appetite
_____Bowel movement changes
_____Abdominal pain
_____Crohn's
_____Colitis
_____Ulcers
_____Other
Explain:

Psychiatric
_____Depression
_____Panic Disorder
_____Schizophrenia
_____Memory Loss
_____Other
Explain:

Musculoskeletal
_____Fibromyalgia
_____Muscular Dystrophy
_____Osteoarthritis
_____Cold Extremities
_____Other
Explain:

Eye/Ear/Nose
_____Tubes in Ears
_____Earaches or Drainage
_____Chronic Sinus Problems
_____Glaucoma
_____Cataracts
_____Eye Turn
_____Hearing Loss Injury
_____Other
Explain:

Endocrine
_____Non insulin dep. Diabetic
_____Insulin dep. Diabetic
_____Thyroid dysfunction
_____Hormonal dysfunction
_____Other
Explain:

Neurological
_____Paralysis
_____Numbness or Tingling
_____Headaches
_____Light Headed or Dizzy
_____Convulsions/ Seizures
_____Tremors
_____Head Injuries
_____Other
Explain:

Cardiovascular
_____Heart Disease
_____Hypertension
_____Stroke
_____Vascular Disease
_____Other
Explain:

Does your child currently receive:
Occupational therapy services?_____
By Whom?_____
Results:_____

Physical therapy services?_____
By whom?_____
Results:_____

Speech therapy services?_____
By whom?_____
Results:_____

Nutritional Information

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Does your child crave sweets?_____
Is your child: ☐ Moderately active ☐ Extremely active
Are there periods of high energy?_____
Low energy?_____

Developmental History

Full term pregnancy?_____Normal birth?_____
Birth weight?_____
Any complications before, during, after 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?_____
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?_____

How would you describe your child's
gross motor skills? (i.e. running, jumping, hopping)___

fine motor skills? (i.e. tying shoes, cutting)_____

Visual History

Previous eye examination:
Date:_____
Doctor's name:_____
Location:_____
Reason for examination:_____

Were glasses prescribed? ☐ Yes ☐ No
How are they worn?_____
Are contact lenses worn? ☐ Yes ☐ No
How are they worn?_____
When was the visual difficulty first noted?_____

Did the problem occur suddenly or related to illness, accident, or trauma? Explain:_____

Have there been any treatments to remedy the problem, such as:
Vision therapy_____
Patching_____
Eye surgery_____
Other_____

Have you seen improvements with therapy?_____

Present Visual Situation

Is there any evidence from any other professional 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 that 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?_____

Yes ☐ No ☐ Head close to paper when reading or 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, re-reads 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

Television viewing: How much?_____
How often?_____Viewing distance?_____
Members of the family who have had visual problems and why:
Name Age Visual Situation

Other related information regarding vision:

School 1st - 12th Grade

Name of Current School:

School Address:

City_____ State_____ Zip_____
School Phone: (_____)_____
Teacher's Name:_____
Grade: _____
Has a grade been repeated? ☐Yes ☐No
Which one?_____
Has he/she changed schools often? ☐Yes ☐No
When?_____
Age at entrance to kindergarten:_____
Age at entrance to first grade:_____
Does child like school? ☐Yes ☐No
Does child like teacher? ☐Yes ☐No
Currently what are average grades overall:

A B C D F

School work/grades in the following classes are at which level? (please check)

	Above Average	Average	Below Average
Reading	_____	_____	_____
Math	_____	_____	_____
Spelling	_____	_____	_____
Writing	_____	_____	_____
Gym	_____	_____	_____

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
Does child like to read voluntarily? ☐Yes ☐No

Has he/she had any special tutoring and/or remedial assistance? ☐Yes ☐No
When?_____
From whom?_____
Where?_____
How long?_____
Results:_____

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

How well developed is his/her spoken vocabulary?

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

Specifically describe any school difficulties:

College/Technical College

Major_____

Specifically describe any school difficulties:

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:_____

Have you ever noticed the following:

Yes ☐ No ☐ Says and/or does things impulsively?
Yes ☐ No ☐ Is in constant motion?
Yes ☐ No ☐ Can't sit still for long periods?
Yes ☐ No ☐ Can't watch TV over 15 minutes?
Yes ☐ No ☐ Speech difficult to understand?
Yes ☐ No ☐ Stutters?
Yes ☐ No ☐ Omits parts of word?
Yes ☐ No ☐ Asks for frequent repetitions?
Yes ☐ No ☐ Difficulty expressing thoughts?

Family and Home (optional)

The following information lets the doctor know who will be performing home therapy with your child. It also lets us know if you need duplicate materials to aid in effective home therapy

Please indicate which adults he/she lives with:
Mother_____ Father_____ Step Mother_____
Step Father_____ Foster Parents _____
Caregiver_____ Grandmother_____
Grandfather_____Aunt_____Uncle_____Other_____
Siblings: Names Ages

_____
_____
_____
_____

If applicable, please describe your child's custody agreement:

_____
_____
_____
_____

Family History (Learning Problems)

Did father or anyone in father's family have learning problems? ☐ Yes ☐ No
Who?_____
_____

Did mother or anyone in mother's family have learning problems? ☐ Yes ☐ No
Who?_____
_____

Do any, or did any of the other children in the family have learning problems? ☐ Yes ☐ No
Who?_____
To what extent?_____
_____
_____

Is there anything else you would like us to know about your child?_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's Name _____Date_____

COVD-Quality of Life Questionnaire

Check the column which best represents the occurrence of each symptom.

Completed by: _____

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Difficulty comprehending what is read					
Holds document/book too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Other comments: