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.

Infant/Toddler History (Birth to 4 years)

Date_____ Completed By_____

How did you learn about A B See?_____

_____

General Information

Child's name

_____
(LAST) (FIRST) (M)

Birth Date_____ Age_____ 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:_____

_____

Any history in your family of the following:

☐ Amblyopia (Lazy eye) ☐ Strabismus (Eye Turn)
☐ Retinal Problems ☐ Other Eye Disease

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: _____
Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Nutritional Information

Does your child crave sweets?_____
Is your child: ☐ Moderately active ☐ Extremely active
Are there periods of high energy? _____
Low energy?_____
Full term pregnancy?_____Normal birth?_____
Birth weight?_____

Developmental History

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?_____

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?_____

Members of the family who have had visual problems and why:
Name Age Visual Situation

Other related information regarding vision:

Sensorimotor Development

For each numbered question please check "yes" or "no". If yes, please check which statements describe your child. If you have additional or different descriptions, please include them under "other".

1. Is your child particularly 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 a shampoo or face wash.
_____Is very picky about textures or 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 with long sleeves and pants; prefers as little clothing as possible.
_____Avoids messy activities, such as play dough, clay, mud pies, finger paints and cooking.
_____Is excessively ticklish.
_____Over reacts to physically painful experiences.
_____Under reacts to physically painful experiences.
_____Tends to withdraw from a group; bump or push 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 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 outing or during physical activities.
_____Has a loose grasp on objects, such as pencils, 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 then the 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 keep it turning.
_____Especially likes movement at home, bouncing on furniture, rocking chair or swiveling chair.
_____Enjoys getting into an upside-down position (feet up, head down).
_____Likes games where 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.
_____Is cautious about heights and climbing.
_____Enjoys movement initiated by themselves but not by others, especially if it's not expected.
_____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? ☐Yes ☐No

_____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:_____
_____
_____
_____

Sensorimotor Development continued

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 any concerns regarding your child's speech and language skills? ☐ Yes ☐ No
Comments:

11. Have you ever had any 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:

Are there any behavior problems? What causes these

General Behavior

problems?

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:

_____
_____
_____
_____

Did father or anyone in father's family have learning

Family History (Learning Problems)

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: