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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

### Psychiatric

- \_\_\_\_\_ Depression  
\_\_\_\_\_ Panic Disorder  
\_\_\_\_\_ Schizophrenia  
\_\_\_\_\_ Memory Loss  
\_\_\_\_\_ Other

Explain:

### Integumentary

- \_\_\_\_\_ Eczema  
\_\_\_\_\_ Rosaces  
\_\_\_\_\_ Psoriasis  
\_\_\_\_\_ Ring Worm  
\_\_\_\_\_ Other

Explain:

### Musculoskeletal

- \_\_\_\_\_ Fibromyalgia  
\_\_\_\_\_ Muscular Dystrophy  
\_\_\_\_\_ Osteoarthritis  
\_\_\_\_\_ Cold Extremities  
\_\_\_\_\_ Other

Explain:

### Constitutional

- \_\_\_\_\_ General Good Health  
\_\_\_\_\_ Recent Weight Change  
\_\_\_\_\_ Fever  
\_\_\_\_\_ Fatigue  
\_\_\_\_\_ Developmental Disability  
\_\_\_\_\_ Other

Explain:

### Eye/Ear/Nose

- \_\_\_\_\_ Tubes in Ears  
\_\_\_\_\_ Earaches or Drainage  
\_\_\_\_\_ Chronic Sinus Problems  
\_\_\_\_\_ Glaucoma  
\_\_\_\_\_ Cataracts  
\_\_\_\_\_ Eye Turn  
\_\_\_\_\_ Hearing Loss Injury  
\_\_\_\_\_ Other

Explain:

### Hematological/ Lymphatic

- \_\_\_\_\_ Anemia  
\_\_\_\_\_ Bleeder  
\_\_\_\_\_ Slow to heal after cut  
\_\_\_\_\_ Leukemia  
\_\_\_\_\_ Large volume blood loss  
\_\_\_\_\_ Enlarged glands  
\_\_\_\_\_ Blood transfusions  
\_\_\_\_\_ Other

Explain:

### Endocrine

- \_\_\_\_\_ Non insulin dep. Diabetic  
\_\_\_\_\_ Insulin dep. Diabetic  
\_\_\_\_\_ Thyroid dysfunction  
\_\_\_\_\_ Hormonal dysfunction  
\_\_\_\_\_ Other

Explain:

### Respiratory

- \_\_\_\_\_ Allergies  
\_\_\_\_\_ Cigarette Smoker  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Bronchitis  
\_\_\_\_\_ Other

Explain:

### Neurological

- \_\_\_\_\_ Paralysis  
\_\_\_\_\_ Numbness or Tingling  
\_\_\_\_\_ Headaches  
\_\_\_\_\_ Light Headed or Dizzy  
\_\_\_\_\_ Convulsions/Seizures  
\_\_\_\_\_ Tremors  
\_\_\_\_\_ Head Injuries  
\_\_\_\_\_ Other

Explain:

### Gastrointestinal

- \_\_\_\_\_ Loss of appetite  
\_\_\_\_\_ Bowel movement changes  
\_\_\_\_\_ Abdominal pain  
\_\_\_\_\_ Crohn's  
\_\_\_\_\_ Colitis  
\_\_\_\_\_ Ulcers  
\_\_\_\_\_ 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
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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 than 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 \_\_\_\_\_

### COVID-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: