Virginia Vision Therapy Center
Developmental Optometry - NeuroOptometry - Low Vision Services

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INFANT AND TODDLER INFORMATION

Date: _____

Contact Information

Full name: _____

Nickname: _____

Birthdate:____/____/____ ___ Yrs, ___ Mos

Social Security # (List parent's #):

_____

Mother's Name: _____

Father's Name: _____

Guardian *if applicable*: _____

Primary Home – *Resides with*:_____

Mailing Address: _____

_____

Home ph # _____

Mother's/Father's occupation:_____

Work ph # _____

Cell ph # _____

Email: _____

Spouse's Occupation:_____

Work ph # _____

Cell ph # _____

Email: _____

Name(s) & age(s) of sibling(s):

_____

_____

How Did You Learn About Our Office?

□ Patient referral: who?_____

□ Professional referral: who?_____

□ Internet □Phone book □ Dr. Davis' Talks

Please send a copy of report to:

□Pediatrician □Referring party

□ Others:_____

_____

_____

_____

_____

Your *Main* Concerns About Your Child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Use back of form if needed

Another family member with similar problem?

_____

Has there been any previous treatment? _____

_____

Revised September 2015

Health History *Check boxes if yes*:

□ ADD/ADHD	□patient	□family
□ Allergy, chronic	□patient	□family
□ Amblyopia	□patient	□family
□ Autism	□patient	□family
□ Asthma	□patient	□family
□ Blindness	□patient	□family
□ Cancer	□patient	□family
□ Cerebral Palsy	□patient	□family
□ Color blindness	□patient	□family
□ Dairy sensitivity	□patient	□family
□ Developmental delay	□patient	□family
□ Dyslexia	□patient	□family
□ Diabetes	□patient	□family
□ Ear infections	□patient	□family
□ Ear tubes	□patient	□family
□ Eye turns	□patient	□family
□ Eye surgeries	□patient	□family
□ Frequent illnesses	□patient	□family
□ Glaucoma	□patient	□family
□ Gluten sensitivity	□patient	□family
□ High fevers	□patient	□family
□ High blood pressure	□patient	□family
□ Head/neck injury	□patient	□family
□ Lactose intolerant	□patient	□family
□ Lazy eye	□patient	□family
□ Learning disabilities	□patient	□family
□ Light sensitive	□patient	□family
□ Patching of eye	□patient	□family
□ Respiratory disease	□patient	□family
□ Seizures	□patient	□family
□ Sleeping problems	□patient	□family
□ Strokes	□patient	□family
□ Speech delay	□patient	□family

□ Other:_____

Medications: _____

_____

Has Your Child Ever Received?

□ Neurological testing? Date:_____

Name and location of provider:_____

_____

□ Psychological testing? Date:_____

Name and location of provider:_____

_____

□ Occupational Therapy? Date:_____

Name and location of provider:_____

_____

□ Physical Therapy? Date:_____

Name and location of provider:_____

_____

□ Speech Therapy? Date:_____

Name and location of provider:_____

_____

□ Vision Therapy? Date:_____

Name and location of provider:_____

_____

□ Date of last eye exam with an eye doctor____

Name and location of provider:_____

_____

Pregnancy and Birth *Check boxes if yes*:

□ Adoption at age ____, birth history unknown

Complications with pregnancy:

□ Anemia □ High blood pressure □ Toxemia

□ Flu □ Measles □ Bleeding □ Vomiting

□ Threatened Miscarriage □ Rh Incompatibility

Medications:_____

_____

□ Prematurity, less than 37 weeks' gestation

□ Birth weight under 5 lbs.

□ Labor over 20 continuous hours

□ Apgar score less than 7 at five minutes

□ More than 2 days in hospital after delivery

□ Breast fed: how long? _____

□ Natural birth □ C-section □ Multiple birth

□ Forceps/suction used □Induction/Pitocin used

□ Fertility treatments used (e.g.IVF)

□ Colic or excessive crying (before age 1)

□ Feeding or digestive problems (before age 1)

□ Poor sucking/swallowing

General Development *Check boxes if yes*:

□ Excessive activity, or under activity (circle one)

□ Poor, uncoordinated crawling (stomach on floor)

□ Walked late (after 18 months) □Required braces

□ Rocking or head banging (circle one)

□ Overly sensitive to touch or noise (circle one)

□ Does not tolerate clothing tags or hair combed

□ Difficulty learning to run with good coordination

□ Age when first rode two-wheeled bicycle ____

□ Does not like climbing

General Behavior *Check boxes if yes*:

Indoor activities: □Drawing □Cutting □Coloring
□Puzzles □Building blocks, Legos
Hours daily: TV__, computers__, videos__
TV viewing distance: ___ feet

Outdoor activities, including sports: _____

_____

Prefers outdoor or indoor activities (circle one)

What does your child like to do:

_____

_____

_____

□ Socializes well with other children
□ Plays alone, or with other children (circle one)
□ Playmates same age
□ Controls play with other children
□ Child ridiculed by other children
□ Difficult to discipline at home
□ Easily distracted
□ Anxious frequently □ Unusual fears
□ Anxious in crowded, busy areas
□ New situations/events (transitions) difficult

When fatigued or stressed:
□excitable □crying spells □withdraws
□meltdowns □tantrums

Signed: _____