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

TOD R. DAVIS OD, FCOVD
AMY E. CARLYLE OD, FAAO
GREG JOHNSON, O.D.
www.VirginiaVisionTherapyCenter.com
703-753-9777

INFANT AND TODDLER INFORMATION

Date: _____

Contact Information

Full name: _____
Nickname: _____

Birthdate:____/____/____ ___ Yrs, ___ Mos
Guardian's Social Security #:
_____
Names of each parent/guardian:
_____
_____
Primary Home Address (*Mailing):* _____
_____
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?_____
As a professional courtesy, we will forward a copy of the report to the referral source unless otherwise marked as follows: □ *Do not send to referral source*

□ Internet □ Phone book □ Dr. Davis' Talks

PLEASE SEND A COPY OF REPORT TO:
(We Will Need The Following to Provide a Copy)

□ **Teacher (Name/Phone/Email or Fax)**
_____
_____

□ **Pediatrician (Name/Phone/Email or Fax)**
_____
_____

□ **Referring party (Name/Phone/Email or Fax)**
_____
_____

□ **Other (Name/Phone/Email or Fax)**
_____
_____

Your Main Concern
Please write the two major concerns about your child's vision and/or learning issues:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Another family member with similar problem?
_____

Has there been any previous treatment? _____
_____

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 births

□ Forceps/suction used □Induction/Pitocin used

□ Fertility treatments used (e.g.IVF)

General Development *Check boxes if yes*:

□ Colic or excessive crying (before age 1)

□ Feeding or digestive problems (before age 1)

□ Poor: sucking - swallowing **(circle one)**

□ Excessive activity / under activity **(circle one)**

□ Poor, uncoordinated crawling (stomach on floor)

□ Walked late (after 18 months) □Required leg braces

□ Rocking - head banging **(circle one)**

□ Overly sensitive to: touch - noise **(circle one)**

□ Does not tolerate: clothing tags - hair combed**(circle one)**

□ 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 - indoor activities **(circle one)**

What does your child like to do:

_____

_____

_____

□ Friends same age

□ Controls play with other friends

□ Child ridiculed by others

Only rate if applies, 1-10, 1(mild / rarely) 10 (unbearable / constantly)

Physical Signs / Complaints										
Headaches, especially after near work	1	2	3	4	5	6	7	8	9	10
Stomach aches	1	2	3	4	5	6	7	8	9	10
Carsickness	1	2	3	4	5	6	7	8	9	10
Exhausted after day of school	1	2	3	4	5	6	7	8	9	10
Blur, even if vision tests “normal”	1	2	3	4	5	6	7	8	9	10
Frequently rubs eyes	1	2	3	4	5	6	7	8	9	10
Turns head to side when watches TV	1	2	3	4	5	6	7	8	9	10
Tilts head during deskwork	1	2	3	4	5	6	7	8	9	10
Closes/covers an eye during deskwork	1	2	3	4	5	6	7	8	9	10
Head gets close to reading material	1	2	3	4	5	6	7	8	9	10
	Score: ____									
Attention										
Attention better listening to story rather than reading	1	2	3	4	5	6	7	8	9	10
Attention better when hands are busy	1	2	3	4	5	6	7	8	9	10
Constantly fidgets in a chair	1	2	3	4	5	6	7	8	9	10
Homework is a battle; child shuts down	1	2	3	4	5	6	7	8	9	10
Poor eye contact; appears to not be listening	1	2	3	4	5	6	7	8	9	10
Can’t locate belongings/ things	1	2	3	4	5	6	7	8	9	10
	Score: ____									
Behavior										
Socializes well with other children	1	2	3	4	5	6	7	8	9	10
Difficult to discipline at home	1	2	3	4	5	6	7	8	9	10
Poor organizational skills	1	2	3	4	5	6	7	8	9	10
Easily distracted	1	2	3	4	5	6	7	8	9	10
Anxious frequently	1	2	3	4	5	6	7	8	9	10
Anxious in crowded, busy areas	1	2	3	4	5	6	7	8	9	10
Unusual fears	1	2	3	4	5	6	7	8	9	10
New situations/events (transitions) difficult	1	2	3	4	5	6	7	8	9	10
Under fatigue/stress, child withdraws	1	2	3	4	5	6	7	8	9	10
Under fatigue/stress, child has meltdowns	1	2	3	4	5	6	7	8	9	10
Child does not like going to school	1	2	3	4	5	6	7	8	9	10
Frequently says “I can’t” before trying	1	2	3	4	5	6	7	8	9	10
Child feels “stupid,” poor confidence	1	2	3	4	5	6	7	8	9	10
	Score: ____									
Coordination and Sports										
Clumsy, poor balance	1	2	3	4	5	6	7	8	9	10
Falls frequently	1	2	3	4	5	6	7	8	9	10
Often knocks things over, esp. at table	1	2	3	4	5	6	7	8	9	10
Dislikes climbing	1	2	3	4	5	6	7	8	9	10
Dizzy, lightheaded easily	1	2	3	4	5	6	7	8	9	10
Difficulties learning bike riding	1	2	3	4	5	6	7	8	9	10
Can’t keep eye on ball, or hit a ball	1	2	3	4	5	6	7	8	9	10
Reads a lot, avoids exercise	1	2	3	4	5	6	7	8	9	10
	Score: ____									

Signed: _____