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

CHILDREN'S 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

IF SO, 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**)
_____
_____

School attended and teacher's name:_____
_____

O.K. to contact teacher? □ YES □ NO
□ Does not apply; my child is homeschooled.

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? _____
_____

Does the child feel that he/she has a problem?
_____

If yes, child's attitude toward the problem: ____
_____

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
□ Other:_____
Medications: _____

_____

Has Your Child Ever Received?

□ Neurological testing? Date:_____
Name and location of provider:_____

_____

□ Psychological testing? Date:_____
Name and location of provider:_____

_____

□ Educational 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

Speech and Language *Check boxes if yes*:

□ Uses restricted oral vocabulary compared to same-age children
□ Mispronounces words
□ Difficulty verbalizing ideas in an organized and coherent manner
□ Difficulty recalling/retelling important facts from a story presented orally
□ Has difficulty understanding humor
□ Has difficulty following verbal instructions
□ Easily distracted by extraneous noises
□ Difficulty being understood by you
□ Avoids speaking in class

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 do well (special talents):

_____

_____

_____

□ Friends same age
□ Controls play with other friends
□ Child ridiculed by others

How does your child deal with his/her learning struggles if present?_____

_____

_____

_____

_____

Education History *Check boxes if yes*:

Current grade: _____

Age at time of entrance to K-grade:___ 1st grade:___

□Repeated grade ___ □Skipped grade___

Easier subjects:

□ Reading □ Spelling □ Writing □ Math

□ Enjoys reading for fun

More difficult subjects:

□ Reading □ Spelling □Writing □ Math

Estimated reading grade level: _____

School work overall is:

□ Average □Above average □Below average

□ Currently enrolled in Special Education (IEP) for: □ Reading □ Spelling □ Writing □ Math

□ If no IEP, currently receives special help/tutoring for: □ Reading □ Spelling □ Writing □ Math

□ Has a 504 plan in place

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: ____									

Reading										
Words run together, move, or double	1	2	3	4	5	6	7	8	9	10
Skips, repeats lines when reading	1	2	3	4	5	6	7	8	9	10
Uses finger to maintain place	1	2	3	4	5	6	7	8	9	10
Slow reader	1	2	3	4	5	6	7	8	9	10
Difficulty reading words (decoding)	1	2	3	4	5	6	7	8	9	10
Can't recognize same word in next line	1	2	3	4	5	6	7	8	9	10
Tires rapidly and loses attention when reading	1	2	3	4	5	6	7	8	9	10
Poor comprehension	1	2	3	4	5	6	7	8	9	10
Omits small words when reading	1	2	3	4	5	6	7	8	9	10
Dislikes chapter books	1	2	3	4	5	6	7	8	9	10
Reads well for short time, then slows	1	2	3	4	5	6	7	8	9	10
	Score: ____									
Writing / Drawing										
Difficulty copying from board	1	2	3	4	5	6	7	8	9	10
Copying takes forever	1	2	3	4	5	6	7	8	9	10
Copies words backwards	1	2	3	4	5	6	7	8	9	10
Reverses numbers, letters, or words	1	2	3	4	5	6	7	8	9	10
Writes up/ down hill	1	2	3	4	5	6	7	8	9	10
Misaligns digits/columns of numbers	1	2	3	4	5	6	7	8	9	10
Struggles to get thoughts on paper	1	2	3	4	5	6	7	8	9	10
Poor pencil grip	1	2	3	4	5	6	7	8	9	10
	Score: ____									
Mathematics										
Difficulty learning to count	1	2	3	4	5	6	7	8	9	10
Poor memory for numbers	1	2	3	4	5	6	7	8	9	10
Difficulty relating a number with real objects(#4 = 4 Cars)	1	2	3	4	5	6	7	8	9	10
Trouble organizing things logically (sorting round objects then square ones)	1	2	3	4	5	6	7	8	9	10
Trouble learning math facts	1	2	3	4	5	6	7	8	9	10
Difficulty with math problem-solving skills	1	2	3	4	5	6	7	8	9	10
Poor memory for math functions	1	2	3	4	5	6	7	8	9	10
Difficulty reading clocks with hands	1	2	3	4	5	6	7	8	9	10
Difficulty reading maps	1	2	3	4	5	6	7	8	9	10
Difficulty measuring things	1	2	3	4	5	6	7	8	9	10
	Score: ____									

Signed: _____