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

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# CHILDREN'S INFORMATION

**Date:** ______________________

## Contact Information

Full name: ______________________________

Nickname: ______________________________

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

Social Security # (List parent's #):

________________________________________

Names of each parent:______________________

________________________________________

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:

□Teacher □ Pediatrician □Referring party

□ Others:______________________________

________________________________________

School attended and teacher's name:_________

________________________________________

*O.K. to contact teacher?* □ YES □ NO

□ Does not apply; my child is homeschooled

## Your Main Concern

About your child's vision and/or learning issues:

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

____________________*Use back of form if needed*

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: ____

________________________________________

*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 |

□ 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 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

**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 or indoor activities (circle one)
What does your child do well (special talents):

__________________________________________
__________________________________________
__________________________________________

□ 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
□ Poor organization skills
□ 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
□ Behavior problems at school
□ Child does not like going to school
□ Frustration, tears during homework
□ Frequently says "I can't" before trying
□ Child feels "stupid"
□ Poor self-confidence
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

**Physical Signs / Complaints**

*If checked yes, rate frequency as*
*1 (occasional), 2 (frequent), or 3 (constant)*

□ 1 2 3 Headaches, especially after near work
□ 1 2 3 Stomach aches
□ 1 2 3 Carsickness
□ 1 2 3 Exhausted after day of school
□ 1 2 3 Blur, even if vision tests “normal”
□ 1 2 3 Frequently rubs eyes
□ 1 2 3 Turns head to side when watches TV
□ 1 2 3 Tilts head during deskwork
□ 1 2 3 Closes/covers an eye during deskwork
□ 1 2 3 Head gets close to reading material

**Score:** ____

**Reading**

□ 1 2 3 Words run together, move, or double
□ 1 2 3 Skips, repeats lines when reading
□ 1 2 3 Uses finger to maintain place
□ 1 2 3 Slow reader
□ 1 2 3 Difficulty reading words (decoding)
□ 1 2 3 Poor comprehension
□ 1 2 3 Omits small words when reading
□ 1 2 3 Can’t recognize same word in next line
□ 1 2 3 Dislikes chapter books
□ 1 2 3 Reads well for short time, then slows

**Score:** ____

**Writing / Drawing**

□ 1 2 3 Difficulty copying from board
□ 1 2 3 Copying takes forever
□ 1 2 3 Writes up/ down hill
□ 1 2 3 Poor pencil grip
□ 1 2 3 Misaligns digits/columns of numbers
□ 1 2 3 Struggles to get thoughts on paper
□ 1 2 3 Copies words backwards
□ 1 2 3 Reverses numbers, letters, or words

**Score:** ____

**Mathematics**

□ 1 2 3 Difficulty learning to count
□ 1 2 3 Poor memory for numbers
□ 1 2 3 Difficulty relating a number with real objects (e.g. the # 4 and 4 cars, 4 children etc.)
□ 1 2 3 Trouble organizing things logically: e.g. sorting round objects, then square ones
□ 1 2 3 Trouble learning math facts
□ 1 2 3 Difficulty with math problem-solving skills
□ 1 2 3 Poor memory for math functions
□ 1 2 3 Difficulty reading clocks with hands
□ 1 2 3 Difficulty reading maps
□ 1 2 3 Difficulty measuring things

**Score:** ____

**Coordination and Sports**

□ 1 2 3 Clumsy, poor balance
□ 1 2 3 Falls frequently
□ 1 2 3 Often knocks things over, esp. at table
□ 1 2 3 Dislikes climbing
□ 1 2 3 Dizzy, lightheaded easily
□ 1 2 3 Difficulties learning bike riding
□ 1 2 3 Can’t keep eye on ball, or hit a ball
□ 1 2 3 Reads a lot, avoids exercise

**Score:** ____

**Attention**

□ 1 2 3 Attention better when listens to story instead of reading on own
□ 1 2 3 Attention better when hands are busy
□ 1 2 3 Needs to put hands on everything
□ 1 2 3 Constantly fidgets in a chair
□ 1 2 3 Homework is a battle; a point is reached where your child “shuts down”
□ 1 2 3 Poor eye contact; seems as though child is not listening
□ 1 2 3 Can’t locate belongings/ things

**Score:** ____

**Total score: ______ (145 maximum)**

**Signed:**___________________________________