VISION THERAPY ASSOCIATES OF YORK
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_____ has an appointment with Dr. _____ on _____. Please complete this history form and bring it with you on the day of your child's appointment.

CHILD HISTORY FORM

CHILD'S FULL NAME _____ AGE _____
Name they preferred to be called _____ BIRTHDAY _____

PARENTS' NAMES _____ OCCUPATION _____

ADDRESS _____
(Street, City, State and Zip Code)
PHONE _____ DAY TIME PHONE NUMBER _____
NAME OF SCHOOL _____ GRADE _____

PRESENT SITUATION

1. Why do you think your child needs a visual examination? _____
_____
_____

2. Who first noted the visual difficulty? _____ When? _____

3. Did this difficulty occur suddenly, or was it related to any specific illness, injury, or other occurance?
_____

4. Have you noted any differences in this child compared to other children (siblings, or playmates)? ___
_____
_____

GENERAL HEALTH

1. Are there any general health considerations/conditions at this time? _____
_____

2. Is this child taking any medications at this time? _____ If so, please list and describe purpose of each _____
_____

3. Is there any history of allergies or asthma? _____ If so, please describe frequency and treatment _____
_____

4. Is there a history of injuries or accidents? _____
_____
Involving head? _____ Involving eyes? _____

5. Are there any difficulties getting this child to eat a balanced, healthy diet (if so, describe)? _____
_____

OVER

DEVELOPMENTAL HISTORY

1. Were there any complications during pregnancy, delivery, or immediately after delivery? _____

2. At what age did your child crawl? _____

3. Was it good "all fours" crawling (if not, describe)? _____

4. At what age did your child walk? _____

5. At what age did your child say his/her first words? _____
What were those words? _____

6. Was speech clear and adequate? _____

7. Is speech clear and adequate now? _____

GENERAL BEHAVIOR

1. Which hand does your child prefer for writing, eating, and in ball play? _____
Was handedness ever changed? _____

2. What activities are included in your child's usual play? _____

3. Is play active or quiet? _____

4. Is your child generally well coordinated (if not, describe)? _____
Involved in sports? _____

5. Is your child good with hands for present age? _____
Are creations good representations of what your child names them to be? _____
Do puzzles, blocks, coloring, drawing, and similar activities hold your child attention? _____
Can your child throw and catch a ball? _____

6. Does your child get along with other children/adults? _____

7. Is your child observant? _____ Distractable? _____

8. Have you noted extreme or frequent fatigue? _____

9. Are there any tensional behaviors such as nail biting, tantrums, eye blinking, excessive rubbing, or rolling of the eyes? _____

10. Does your child need an unusual amount of sleep? _____

11. Does your child have frequent accidents, spills, or bump into and trip over objects frequently? _____

SCHOOL

1. At what age did your child enter school? _____

2. Was any grade ever repeated? _____ Why? _____

3. How is your child doing in school? _____
_____

4. Is your child performing up to his/her potential? _____
If not, what do you think is the problem? _____
_____

5. What is your child's best subject (s)? _____ Hardest? _____
Favorite? _____ Least Favorite? _____

6. Does your child like school? _____ Teacher? _____ Other Children? _____

7. What does your child report about school? _____

8. What does your child's teacher report about your child? _____

9. Has your child had any remedial work (when and in what subject)? _____
_____

10. Is your child in any special classes/programs in school currently? _____
Where and Why? _____

11. Does your child like to read? _____ Be read to? _____

12.How frequently does your child read or look at book by their own motivation? _____

13. If your child is having difficulty reading, does it seem to be with learning sight words, phonetically sounding out words, fluidity and speed, sustaining close work activities, or a combination of these?
_____

VISUAL HISTORY AND CHECKLIST

1. Has there been previous visual care (when and where)? _____
_____

2. Does your child have glasses/contact lenses? _____ At what age did they begin wearing glasses? _____ Why and when are they to be worn? _____
When are they actually worn? _____ Is this with or without your prompting? ____
_____ How frequently has the prescription been changed?_____

3. Is there any history of an eye turning, lazy eye, eye disease, eye surgery, eye injury, vision therapy, or patching? _____
_____

4. Have parents, brothers, or sisters had visual care? _____
For what reason? _____

OVER

5. Please circle the appropriate response for each symptom:

F (frequently) O (occasionally) R (rarely) N (never)

F O R N	Blurred Vision
F O R N	Watering, tired, strained, sore, burning eyes (circle ones which apply)
F O R N	Double vision
F O R N	Headaches late in day or with close work
F O R N	Difficulty keeping place while reading
F O R N	Uses finger or marker to keep place
F O R N	Slow or word-by-word reading
F O R N	Avoid reading or close work
F O R N	Words running together or moving
F O R N	Difficulty copying from chalkboard or book
F O R N	Confuses similar words
F O R N	Reversing words or letters
F O R N	Confuses left and right
F O R N	Dizziness or nausea with close work or in car
F O R N	Difficult remembering/comprehending what was read
F O R N	Holds head close to reading material
F O R N	Turns, tilts, or moves head while reading
F O R N	Closes or covers an eye while reading or outside
F O R N	Poor handwriting
F O R N	Awkward posture or pencil grip when writing
F O R N	Tension, nervousness, frustration with close work
F O R N	Bright light bothering eyes

Please include any additional comments or pertinent information:_____
_____
_____
_____
_____