The**VISION**Development Team

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General Information

Child's full name________________________________
Age__________ Birth date ________________________
School____
School Address___________________________________
____
Grade ______Teacher______________________________
Principal____
Is your child especially afraid of doctors? Yes No

Parent Information

Father's Full Name_______________________________
Home Address Same as patient address on Welcome Form
Address__________________________________
City __________________State ________Zip__________
Phone: H_________________ C___________________
E-mail____
Father's occupation______________________________
Employer____
Work Phone_______________________________________

Mother's Full Name_______________________________
Home Address Same as patient address on Welcome Form
Address__________________________________
City __________________State ________Zip__________
Phone: H_________________ C___________________
E-mail____
Mother's occupation______________________________
Employer____
Work Phone_______________________________________

Medical History

Most recent medical examination:
Doctor's name____________________________________
Date____
Results____
____
Medications currently using? ________________________
For what condition? ______________________________
Drug allergies___________________________________

School Age Child History

Please bring this form to your child's appointment ***or return by email before the appointment. If your child has had an Individualized Education Program (IEP), or other testing which Dr. Andrich should be aware of, please provide a copy.***

Has your child been diagnosed as having:

Learning disabilities	Developmental delays
ADD or ADHD	Cerebral Palsy
Seizure disorders	Autism
Brain injury	Dyslexia

Other__________________________________

List illnesses, bad falls, head injuries, ear infections, high fever etc. (include complications and ages)
____
____
____
____
____
____

Is your child generally healthy?______________________
Are there any chronic problems like asthma, hay fever, allergies?____
If so, please list_________________________________
____
____
____

Has a neurological evaluation been performed? Yes No
By whom?____
Results____
____
____

Has a psychological evaluation been performed? Yes No
By whom?____
Results____
____

Does your child currently receive:

Occupational therapy services? Yes No
By whom?____
Results____
____

Physical therapy services? Yes No
By whom?____
Results____
____

Speech therapy services? Yes No
By whom?____
Results____
____

Other therapy services? Yes No
Describe____
____

Nutritional Information

Current Diet: Excellent Good Fair Poor
Does your child crave sweets?__________________________
Is your child Moderately active Extremely active
Are there periods of high energy? Yes No
Low energy? Yes No

Developmental History

Full term pregnancy? Yes No Normal Birth? Yes No
Birth weight?____________________________________
Any complications before, during, after or immediately following delivery?______________________________
Did your child crawl (stomach **on** floor)? Yes No
Age____
Did your child creep (stomach **off** floor)? Yes No
Age____
Did your child move on all fours? Yes No
Age____
If not describe_______________________________________
____
At what age did your child walk?________________________
Was child active? Yes No
Speech: First words at age____________________________
Was early speech clear to others? Yes No
Is it clear now? Yes No
Any history of crossing eyes? Yes No
What age first noticed_________________________________
Any **family** history of crossing eyes? Yes No
Who?____

Visual History

Previous eye examination: Doctor's name________________
____
Date____
Reason for examination________________________________
Results____
____
Were glasses prescribed? Yes No
Are they worn? Yes No Full-time Part-time
Comments____
Are eye exams done yearly? Yes No
Members of the family who have had visual attention and why:

Name	Age	Visual Situation

Present Situation

Is there any concern from any other professional that some visual dysfunction may be present? Yes No
Describe____
____
____
____

Does your child report any of the following:
Headaches Yes No
When?____
Blurred vision Yes No
When?____
Double vision Yes No
When?____
Eyes "hurt or tired" Yes No
When?____
List any other complaints that your child makes concerning his/her vision____________________________________
____
____
____
____
____
____

Have you ever noticed the following:

Eyes frequently reddened Yes No
If so, when?____
Frequent eye rubbing Yes No
If so, when?____
Frequent blinking Yes No
If so, when?____
Closing or covering one eye Yes No
If so, when?____

Head close to paper when reading or writing	Yes	No	N/A
Tilting head when reading	Yes	No	N/A
Tilting head when writing	Yes	No	N/A
Confuses letters or words	Yes	No	N/A
Reverses letters or words	Yes	No	N/A
Skips, rereads or omits words	Yes	No	N/A
Vocalizes when reading silently	Yes	No	N/A
Reads slowly	Yes	No	N/A
Uses finger as a marker	Yes	No	N/A
Poor reading comprehension	Yes	No	N/A

Writes or prints poorly	Yes	No	N/A
Tires easily	Yes	No	N/A
Avoids near tasks	Yes	No	N/A
Short attention span	Yes	No	N/A
Poor motor coordination	Yes	No	N/A
Difficulty catching/hitting a ball	Yes	No	N/A

Television viewing: How much__________________________

How often________________Viewing distance_____________

Average amount of sleep per night_____________________

School

Age at entrance to kindergarten__________________________

Does child like school? Yes No

Teacher? Yes No

School work is: Above Average
Average
Below Average

Do you feel he/she is working up to potential?
____

Does teacher feel he/she is working up to potential?
____

What school subjects come easy for child?
____
____
____

Does child like to read? Yes No

Voluntarily? Yes No

What?____
____

Specifically describe any school difficulties:
____
____
____
____

Has a grade been repeated? Yes No

Which?____

Has he/she changed schools often?____________________

When?____

Does he/she seem to be under tension or extreme pressure when doing schoolwork?________________________________

Has he/she had any special tutoring and/or remedial assistance? Yes No

When?____

From whom?____

Where?____

How long?____

Results____
____

How well developed is his/her spoken vocabulary?
____

What is the child's attitude toward reading, school, his/her teacher, other youngsters?_____________________________
____
____

General Behavior

Are there any behavior problems? Yes No

School___________________Home____________________

What causes these problems?
____
____

Child's reaction to fatigue: None Sad Irritable
Other____

Child's reaction to tension? None Nail biting
Thumb sucking Other________________________________

Does he/she say and/or do things impulsively?	Yes	No
Is your child in constant motion?	Yes	No
Can your child sit still for long periods?	Yes	No

Family and Home

Please indicate which adults he/she lives with:
Mother Father Step Mother Step Father
Foster Parents Adopted Parents Grandmother
Grandfather Aunt Uncle
Other____

Siblings:	Names	Ages

If applicable, please describe your child's custody agreement:
____
____
____
____

Has he/she ever been through a traumatic family situation? (Such as divorce, parental loss, separation) Yes No

What age was he/she?_________________________________

Does he/she seem to have adjusted?____________________

Is family life stable at this time? Yes No

How does he/she get along with parents?_________________

Siblings?
Classmates at school?
Playmates at home?
Did anyone in father's family have a learning problem? Yes No
Who?

Did mother or anyone in mother's family have a learning problem? Yes No
Who?

Do any, or did any of the other children in the family have learning problems? Yes No

Who?
To what extent?

Give a brief description of your child as a person:

Additional comments/concerns that you would like Dr. Andrich to be aware of:

Report Policies

Would you like copies of any reports? Yes No
Would you like copies sent anywhere? Yes No
Name

Address

Name

Address

Name

Address

(For any others please use the back of this form)

Please sign below to give us permission to release information about your child to the above sources.

Signed
Date