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Young Child History

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

Patient Information

Child's full name_____
Age_____Birthdate_____
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?_____

Any history in your family of the following?

☐ Amblyopia (Lazy Eye) ☐ Strabismus (Eye Turn)
☐ Retinal Problems ☐ Other Eye Disease

Has your child been diagnosed as having:

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

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
List any other treatments or recommendations you have received regarding your child's vision:_____
_____
_____
_____

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_____
_____
_____
_____
_____
_____
_____

Sensorimotor Development

For each question please check "yes" or "no" and then check each of the subsequent statements, which describe your child. Your responses will probably be most accurate if you read all of the descriptions under the question before selecting "yes" or "no". If you have additional of different descriptions, please include them under "other".

1. **Is your child particularly sensitive to touch?** □ Yes □ No
_____ Did not always find touch to be calming or pleasurable as an infant.
_____ Is more annoyed than other children the same age by having a shampoo or face wash.
_____ Is very picky about textures or clothing.
_____ Is very fussy about the clothing, (e.g. dislikes collars; dislikes having to button the top button of a shirt; is uncomfortable in hats, etc.)
_____ Is uncomfortable with long sleeves and pants; prefers as little clothing as possible.

_____ Avoids messy activities, such as playdough, clay, mudpies, fingerpaints, and cooking.
_____ Is excessively ticklish.
_____ Overreacts to physically painful experiences.
_____ Underreacts to physically painful experiences.
_____ Tends to withdraw from a group, or bump or push others in a group; is irritable in close quarters.
Other:_____
_____
_____
_____

2. **Does your child have trouble with gross motor or posture?** ☐ Yes ☐ No
_____ Tends to slump in chair or sprawl over chair and table.
_____ Does not feel very "firm" when you lift child up or move child's limbs to dress.
_____ Has difficulty turning knobs or handles which require some pressure.
_____ Fatigues easily during family outings or during physical activities.
_____ Has a loose grasp on objects, such as pencils, scissors, spoon or something he/she is carrying.
_____ Has a rather tight, tense grasp on objects.
Other:_____
_____
_____

3. **Does your child particularly enjoy fast-moving or spinning equipment at the playground or at home, seeming to be less dizzy than the others or not dizzy at all?** ☐ Yes ☐ No
_____ Likes to swing very high and/or for a long time.
_____ Frequently rides the playground merry-go-round when others help keep it turning.
_____ Especially likes movement at home, bouncing on furniture, rocking chair or swiveling chair.
_____ Enjoys getting into an upside-down position (feet up, head down.)
_____ Likes games where vision is occluded, keeping eyes closed for fun or using a blindfold.
_____ Enjoys most of the fast and "scary" kiddy rides when at an amusement park.
Other:_____
_____
_____
_____

4. **Does your child show particular caution in approaching activities involving fast movement or movement of the body through space?** ☐ Yes ☐ No
_____ Tends to avoid swings or slides or uses them with hesitation.
_____ Does not like riding a see-saw or going up and down an escalator.
_____ Is cautious about heights and climbing.
_____ Enjoys movement initiated by him/her self but not by others, especially if it's not expected.
_____ Dislikes trying new movement activities or has difficulty learning them.
_____ Has difficulty climbing or descending stairs or hills.
_____ Tends to get motion sickness in a car, airplane, or elevator.
Other:_____
_____
_____
_____

5. **Do you feel your child has already established a definite hand preference or dominance?** ☐ Yes ☐ No
_____ Prefers the right hand.
_____ Prefers the left hand.
Comments:_____
_____
_____
_____
_____

6. **Can your child easily orient his/her body effectively for dressing activities, such as putting arms in sleeves, putting fingers in mittens or putting toes in socks?** ☐ Yes ☐ No
Comments:_____
_____
_____
_____
_____

7. **Does your child spontaneously engage in active physical games involving running, jumping, and use of large play equipment?** ☐ Yes ☐ No
Comments:_____
_____
_____
_____
_____

8. **Does your child spontaneously seek out activities requiring manipulation of small objects?** ☐ Yes ☐ No
Comments:_____
_____
_____
_____
_____

9. **Does your child spontaneously choose to do activities involving the use of "tools", such as crayons, pencils, markers, scissors, etc?** ☐ Yes ☐ No
Comments:_____
_____
_____
_____
_____

10. **Have you ever had any concerns regarding your child's speech and language skills?** ☐ Yes ☐ No
Comments:_____
_____
_____

11. **Have you ever had any concerns regarding your child's hearing, either in general or in conjunction with ear infections?**

☐ Yes ☐ No

Comments:_____

_____

_____

_____

_____

12. **Is your child particularly sensitive to noise (for example puts hands over ears when others are not bothered by sounds)?**

☐ Yes ☐ No

Comments:_____

_____

_____

_____

_____

13. **Do you feel that your child has an adequate attention span for things which he/she enjoys?** ☐ Yes ☐ No

Comments:_____

_____

_____

_____

_____

14. **Do you feel that your child tends to be restless or "fidgety" during times when quiet concentration is required?**

☐ Yes ☐ No

Comments:_____

_____

_____

_____

_____

General Behavior

Are there any behavior concerns? What causes theses concerns? _____

_____

_____

_____

_____

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?_____

Give a brief description of your child as a person:_____

_____

_____

_____

_____

_____

_____

Report Policies

Would you like copies of any reports? ☐ Yes ☐ No

Would you like copies sent anywhere? ☐ Yes ☐ No

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_____