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Please bring this form to your child's appointment. This assists us in determining the visual performance tests needed. If your child has an Individual Education Plan (IEP), or other testing which we should be aware of, please provide a copy.

Infant/Toddler History (Birth to 4 years)

Date _____ Completed By _____
How did you learn about A B See? _____

General Information

Child's name _____
(LAST) (FIRST) (M)
Birth Date _____ Age _____ Gender F M
Home Address _____
City _____ State _____ Zip _____
Name of Health Care Plan _____
Policy Holder _____
Policy number _____ Group # _____
Medical Billing Address _____
Pediatrician _____
Pediatrician's phone number _____

Parent Information

Father's name _____
(LAST) (FIRST) (M)
Home Address _____
City _____ State _____ Zip _____
Home phone () _____
Cell phone () _____
E-mail _____
Father's occupation _____
Employer _____
Work phone () _____
May we contact you at your business? Yes No

Mother's Name _____
(LAST) (FIRST) (M)
Home Address _____
City _____ State _____ Zip _____
Home phone () _____
Cell phone () _____
E-mail _____
Mother's occupation _____
Employer _____
Work phone () _____
May we contact you at your business? Yes No

Responsible Party _____
Phone _____

Medical History

Most recent medical examination:
Date: _____
Doctor's name: _____
Results: _____

Current Medications:	Taken For:

Is your child generally healthy? _____
Are there any chronic problems like asthma, hay fever or allergies? _____
If so, please list: _____

Has a neurological evaluation been performed? _____
By whom? _____
Results: _____

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
 Other problems _____

List illnesses, bad falls, head injuries, high fever, surgeries etc. _____

Complications and ages: _____

Medical History continued

Please check any of the following which your child has or has had in the past:

Allergies/ Immunology

- _____ Drug Allergies
_____ Environmental Allergy
_____ Rheumatoid Arthritis
_____ Lupus
_____ Other

List all allergies

Integumentary

- _____ Eczema
_____ Rosaces
_____ Psoriasis
_____ Ring Worm
_____ Other

Explain:

Constitutional

- _____ General Good Health
_____ Recent Weight Change
_____ Fever
_____ Fatigue
_____ Developmental Disability
_____ Other

Explain:

Hematological/ Lymphatic

- _____ Anemia
_____ Bleeder
_____ Slow to heal after cut
_____ Leukemia
_____ Large volume blood loss
_____ Enlarged glands
_____ Blood transfusions
_____ Other

Explain:

Respiratory

- _____ Allergies
_____ Cigarette Smoker
_____ Asthma
_____ Bronchitis
_____ Other

Explain:

Gastrointestinal

- _____ Loss of appetite
_____ Bowel movement changes
_____ Abdominal pain
_____ Crohn's
_____ Colitis
_____ Ulcers
_____ Other

Explain:

Psychiatric

- _____ Depression
_____ Panic Disorder
_____ Schizophrenia
_____ Memory Loss
_____ Other

Explain:

Musculoskeletal

- _____ Fibromyalgia
_____ Muscular Dystrophy
_____ Osteoarthritis
_____ Cold Extremities
_____ Other

Explain:

Eye/Ear/Nose

- _____ Tubes in Ears
_____ Earaches or Drainage
_____ Chronic Sinus Problems
_____ Glaucoma
_____ Cataracts
_____ Eye Turn
_____ Hearing Loss Injury
_____ Other

Explain:

Endocrine

- _____ Non insulin dep. Diabetic
_____ Insulin dep. Diabetic
_____ Thyroid dysfunction
_____ Hormonal dysfunction
_____ Other

Explain:

Neurological

- _____ Paralysis
_____ Numbness or Tingling
_____ Headaches
_____ Light Headed or Dizzy
_____ Convulsions/Seizures
_____ Tremors
_____ Head Injuries
_____ Other

Explain:

Cardiovascular

- _____ Heart Disease
_____ Hypertension
_____ Stroke
_____ Vascular Disease
_____ Other

Explain:

Does your child currently receive:

Occupational therapy services? _____

By Whom? _____

Results: _____

Physical therapy services? _____

By whom? _____

Results: _____

Speech therapy services? _____

By whom? _____

Results: _____

Current Diet: Excellent Good Fair Poor

Nutritional Information

Does your child crave sweets? _____

Is your child: Moderately active Extremely active

Are there periods of high energy? _____

Low energy? _____

Full term pregnancy? _____ Normal birth? _____

Birth weight? _____

Developmental History

Any complications before, during, after or immediately following delivery? _____

Did your child crawl (stomach on floor)? _____

Age: _____

Did your child creep (stomach off floor)? _____

Age: _____

Did your child move on all fours? _____

Age: _____

If not describe: _____

At what age did your child walk? _____

Was child active? _____

Speech: First words at age: _____

Was early speech clear to others? _____

Is it clear now? _____

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:

Date: _____

Doctor's name: _____

Location: _____

Reason for examination: _____

Were glasses prescribed? Yes No

How are they worn? _____

Are contact lenses worn? Yes No

How are they worn? _____

When was the visual difficulty first noted? _____

Did the problem occur suddenly or related to illness, accident or trauma? Explain: _____

Have there been any treatments to remedy the problem, such as:

Vision therapy _____

Patching _____

Eye surgery _____

Other _____

Have you seen improvements with therapy? _____

Present Visual Situation

Is there any evidence from any other professional that some visual malfunction may be present? _____

If so, what? _____

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? _____

Members of the family who have had visual problems and why:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other related information regarding vision:

Sensorimotor Development

For each numbered question please check "yes" or "no".
If yes, please check which statements describe your child.
If you have additional or 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 play dough, clay, mud pies, finger paints and cooking.
- _____ Is excessively ticklish.
- _____ Over reacts to physically painful experiences.
- _____ Under reacts to physically painful experiences.
- _____ Tends to withdraw from a group; 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 outing 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" kiddie 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 themselves 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: _____

Sensorimotor Development continued

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: _____

General Behavior

Are there any behavior problems? What causes these problems? _____

Family History (Learning Problems)

Did father or anyone in father's family have learning problems? Yes No

Who? _____

Did mother or anyone in mother's family have learning problems? Yes No

Who? _____

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

Who? _____

To what extent? _____

Is there anything else you would like us to know about your child? _____

Family and Home (optional)

The following information lets the doctor know who will be performing home therapy with your child. It also lets us know if you need duplicate materials to aid in effective home therapy.

Please indicate which adults he/she lives with:

Mother _____ Father _____ Step Mother _____

Step Father _____ Foster Parents _____

Caregiver _____ Grandmother _____

Grandfather _____ Aunt _____ Uncle _____ Other _____

Siblings: Names _____ Ages _____

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

Patient's Name _____ Date _____

COVID-Quality of Life Questionnaire

Check the column which best represents the occurrence of each symptom.

Completed by: _____

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Difficulty comprehending what is read					
Holds document/book too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Other comments: