learn to see
vision clinic

Welcome to our office!

Please fill out the background history form as completely as possible and return to the office before your appointment. Thank you!

Name _____Birth date_____/_____/_____ Age_____

Address_____

Home Phone_____ Cell Phone_____ Email_____

Parents Names Occupation Work Phone

1. _____

2. _____

Siblings Names and Ages_____

_____

Child care experience? Where? How many years? How many hours per week?

_____

_____

Vision and Health History

In what ways does your child seem to have difficulty with their vision? _____

_____

Previous visual examinations (list reason for exams and results)_____

_____

Have any other family members had vision concerns? Please describe._____

_____

Is there a family history of learning difficulties?_____

_____

Was pregnancy full-term?_____ Any complications before, during or after the birth?_____

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Medications_____Allergies_____

List any history of illnesses, surgeries, or accidents (including ear infections) _____

_____

Pediatrician's Name and Address_____

_____

Play and Development History

Developmental Milestones- Please circle one early - late - on time

Rolling Over early - late - on time

Reaching for Objects early - late - on time

Crawling early - late - on time

Walking early - late - on time

First Words early - late - on time

Sentences early - late - on time

Draws Shapes early - late - on time

Walking up Stairs early - late - on time

Anything unusual about your child's development?_____

_____

How much time each day does your child spend with the TV or computer?_____

_____

How much time per day does your child spend outside?_____

What kinds of play are favorites? _____

What kinds of play are avoided or of no interest?_____

Activities your family enjoys together?_____

List any special testing and the results? Please include copies if possible. _____

_____

Has your child received additional special education assistance? _____

_____

Describe your child._____

_____

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Child's interests_____

Child's response to stress or fatigue_____

Is there anything you wish to discuss when your child is not present?_____

_____

Risk Factors for Potential Vision Concerns

Physical symptoms and skips or struggles with sequences in development can be signs of a vision dysfunction. While every child progresses at their own developmental pace, each developmental step has significance in later learning potential. Careful observation of everyday play and learning can help uncover potential vision concerns.

Checklist--Please check all that apply

- Frequent eye rubbing, squinting or blinking
- Holds head too close to objects
- Tilting or turning head
- Eyes in constant motion
- One eye turns in or out when tired
- Eyes often look red or tired
- Excessive tearing or eye matter
- Closing or covering one eye
- Early walker or bypassed crawling
- Tip toe walking
- Poor balance, clumsy
- Difficulty anticipating events
- Startles easily
- Difficulty with stairs
- Unusual fear of heights or movement on outdoor play equipment
- Difficulty catching a big ball
- Poor motor coordination
- Lack of interest in books
- Lack of interest in exploring
- Avoids fine motor activities
- Poor color or shape recognition
- Poor size concepts
- Inability to follow simple directions
- Unusually short attention span
- Difficulty with buttons, scissors, pencil grip
- Lack of a preferred hand
- Other developmental delays