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YOUNG CHILD HISTORY

Please fill out this form <u>carefully</u> and bring it with you to your appointment.

A. GENERAL INFORMATION

Child's full name ____ Present age ______ Birth date ______________

Is your child especially afraid of doctors? O Yes O No

Referred by: ____

B. FAMILY

Father ____ Birth date ___________________________

Mother ____ Birth date ___________________________

Brothers ____ Birth date ___________________________

& ____ Birth date ___________________________

Sisters ____ Birth date ___________________________

C. PARENT INFORMATION

Home address ____ City __________________ State ____ Zip _________

Occupation ____ Home Phone _________________________

Email ____ Fax Number ___________________________

Mother Employer ____ Business Phone _______________________

Business address ____ City __________________ State ____ Zip _________

Father Employer____ Business Phone _________________________

Business address ____ City __________________ State ____ Zip _________

Do you have Major Medical Insurance? O Yes O No

If so, what is the carrier? _________________________________ Policy # _______________________________________

D. MEDICAL HISTORY

Child's most recent medical examination: ____

Doctor's name Date

____

Results

Medications currently using: For what condition:

____

____

Any history of the following in your family? O Diabetes O Glaucoma O High Blood Pressure

Has your child been diagnosed as having any of the following?

O Learning Disabilities O Developmental delays O ADD or ADHD O Cerebral Palsy

O Seizure disorders O Autism O Other ____

List illnesses, bad falls, head injuries, high fevers, etc.

____

____

Is your child generally healthy? O Yes O No

Are there any chronic problems like asthma, hay fever, allergies? O Yes O No If so, please list: ___________________

____

Has a Neurological Evaluation been performed? O Yes O No By whom? ______________________________________

Results? ____

Has a Psychological Evaluation been performed? O Yes O No By whom? _____________________________________

Results? ____

Does your child currently receive:

O Occupational therapy services? By Whom? ____

Results? ____

O Physical therapy services? By Whom? ____

Results? ____

O Speech therapy services? By Whom? ____

Results? ____

O Other therapy services? By Whom? ____

Results? ____

E. *NUTRITIONAL INFORMATION*

Current diet: O Excellent O Good O Fair O Poor

Does your child like or crave sweets? O Yes O No

Is your child active? O Not active O Moderately active O Extremely active

Are there periods of very high energy? O Yes O No low energy? O Yes O No

F. *DEVELPOMENTAL HISTORY*

Full term pregnancy? O Yes O No Normal birth? O Yes O No

Any complications before, during, or immediately following delivery? ____

Did your child crawl (stomach on floor)? O Yes O No Age? _____

creep (stomach off floor)? O Yes O No Age? _____

move on all fours? O Yes O No If not, please describe ____

At what age did your child walk? _____________ Was child active? O Yes O No

Speech: First words at age _______________ Was speech clear to others? ____________________________________

Is it clear now? O Yes O No Explain: ____

Any history of crossing eyes? O Yes O No What age first noticed? ____

Any *family* history of crossing eyes? O Yes O No Who? ____

G. *VISUAL HISTORY*

Child's most recent vision examination: ____

Doctor's name Date

____

Results

Reason for examination: ____

Were glasses prescribed? O Yes O No Are they worn? O Yes O No When? ___________________________

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

Name	Age	Visual Situation

H. PRESENT SITUATION

Is there any evidence from the school or psychological tests that some visual malfunction may be present? O Yes O No

If so, what ____

Does your child report any of the following?

Headaches	O Yes O No	When? ____________________
Blurred vision	O Yes O No	When? ____________________
Double vision	O Yes O No	When? ____________________
Eyes "hurt" or "tired"	O Yes O No	When? ____________________

List any other complaints your child makes concerning his/her vision. ______________________________

____

Have you ever noticed the following?	**Yes**	**No**	**If so, when?**
Eye frequently reddened	O	O	____________________
Frequent eye rubbing	O	O	____________________
Frequent blinking	O	O	____________________
Closing or covering one eye	O	O	____________________

Television viewing How much ____________ How often ____________ Viewing Distance __________

I. 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 or different descriptions, please include them under "*Other*".

1. Is your child particularly sensitive to touch? O Yes O No

O Did not always find touch to be calming or pleasurable as an infant.
O Is more annoyed than other children the same age by having a shampoo or face wash.
O Is very picky about textures or clothing.
O 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).
O Is uncomfortable with long sleeves or pants; prefers as little clothing as possible.
O Prefers long sleeves and pants, even in warm weather.
O Avoids messy activities, such as play dough, clay, mud pies, finger paints, and cooking.
O Is excessively ticklish.
O Overreacts to physically painful experiences
O Under reacts to physically painful experiences
O 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? O Yes O No

O Tends to slump in chair or sprawl over chair and table.
O Does not feel very "firm" when you lift child up or move child's limbs to dress.
O Has difficulty turning knobs or handles which require some pressure.
O Fatigues easily during family outings or during physical activities.
O Has a loose grasp on objects, such as a pencil, scissors, spoon, or something (s)he is carrying.
O 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 others or not dizzy at all? O Yes O No

O Likes to swing very high and/or for long periods of time.
O Frequently rides the playground merry-go-round when helping others help keep it turning.
O Especially likes movement at home, bouncing on furniture, rocking chair, or swiveling in a chair.
O Enjoys getting into an upside-down position (feet up, head down).
O Likes games where vision is occulated, keeping eyes closed for fun or using a blindfold.
O 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? O Yes O No

O Tends to avoid swings or slides or uses them with hesitation.
O Does not like riding a see-saw or going up and down an escalator.
O Is cautious about heights and climbing.
O Enjoys movement initiated by himself/herself, but nor by others, especially if it’s unexpected.
O Dislikes trying new movement activities or has difficulty learning them.
O Has difficulty climbing or descending stairs or hills.
O Tends to get motion sickness in a car, airplane, or elevator.
OTHER: ____

5. Do you feel that your child has already established a definite hand preference or dominance? O Yes O No

O Prefers the right hand.
O 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? O Yes O No

COMMENTS: ____

7. Does your child spontaneously engage in active physical games involving running, jumping, and use or large play equipment? O Yes O No

COMMENTS: ____

8. Does your child spontaneously seek out activities requiring manipulation of small objects? O Yes O No

COMMENTS: ____

9. Does your child spontaneously choose to do activities involving the use of “tools”, such as crayons, pencils, markers, scissors, etc.? O Yes O No

COMMENTS: ____

10. Have you ever had concerns regarding your child’s speech and language skills? O Yes O No

COMMENTS: ____

11. Have you ever had concerns regarding your child’s hearing, either in general or in conjunctions with ear infections?
O Yes O No

COMMENTS: ____

12. Is your child particularly sensitive to noise (for example, puts hands over ears when others are not bothered by sounds)? O Yes O No

COMMENTS: ____

13. Do you feel that your child has an adequate attention span for things which (s)he enjoys? O Yes O No
COMMENTS: ____

14. Do you feel that your child tends to be restless or "fidgety" during times when quiet concentration is required?
O Yes O No
COMMENTS: ____

J. *GENERAL BEHAVIOR*

Are there any behavior problems? School O Yes O No Home O Yes O No
What causes these problems? ____
____
Child's reaction to fatigue? O Sag O Irritable O Other ________________________________
Child's reaction to tension? O Nail biting O Thumb sucking O Other ________________________________
Does (s)he say and/or do things impulsively? O Yes O No In constant motion? O Yes O No
Can the child stay still for long periods of time? O Yes O No

K. *FAMILY AND HOME*

Please indicate which adults the child lives with: O Mother O Father O Step Mother O Step Father O Aunt
O Uncle O Grandmother O Grandfather O Adoptive Parents O Foster Parents O Other

Has (s)he been through a traumatic family situation?(Such as divorce, parental loss, separation, severe parental illness) O Yes O No
What age was the child when this situation occurred? ___________ Has the child adjusted? O Yes O No
Is family life stable at this time? O Yes O No
How does (s)he get along with:
Parents? ____
Siblings? ____
Classmates in school? ____
Playmates at home? ____

Did father or anyone in father's family have a learning problem? O Yes O No If so, who? ______________________
If so, who? __________________ Explain ____
Did mother or anyone in mother's family have a learning problem? O Yes O No If so, who? ______________________
If so, who? __________________ Explain ____
Is there any history of mental retardation, psychological disturbance, etc. on either side of the family? O Yes O No
If so, who? __________________ Explain ____
Any of the other children in the family have a history of learning problems? O Yes O No
If so, who? __________________ Explain ____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:
____
____
____
____

L. *REPORT POLICIES*

Would you like copies of any reports? O Yes O No Would you like copies of any reports sent to anyone else? If so, please list name and address. ____

Please sign below to give us permission to release information about your child to the above sources. (Valid for 90 days only)

Signed ____ Date ______________________