orthovision
center for intelligent vision

Developmental History Intake Form

October 2018

Child's name _____ Birthdate ____ /____ /____ FIN/IC #_____

Grade _____ School's name _____

Mother's name _____ Occupation _____ Phone _____

Father's name _____ Occupation _____ Phone _____

Home Phone _____ E-mail address: _____

May we send you occasional emails / newsletters ❑ Yes ❑ No
SMS Reminders ❑ Yes ❑ No

Mailing address _____

Number of children in family _____ Who referred you to this clinic? _____

I. Please state the **main reason** you would like your child examined: _____

_____

II. Vision Questionnaire

	Yes	No	Unknown
1. Headaches			
2. Blurred distant vision			
3. Blurred reading vision			
4. Holds books closer than normal			
5. Eyes hurt			
6. Eyes tire			
7. Double vision			
8. Eye turn (crossed or "wall-eyed")			
9. Blinks excessively			
10. Covers one eye while doing homework			

III. Physical / Cognitive / Spatial Development

At what age in years and months did the child:

Speak words clearly? _____ Start to crawl? _____ Walk unaided? _____

Which phrase describes the child's **physical maturity** (circle number)?

1 - Physically immature for age
2 - Average physical maturity for age
3 - Advanced physical maturity for age

	Yes	No	Unknown
1. Did your child have any difficulty feeding in the first weeks of life, or in keeping food down?			
2. Was your child extremely demanding in the first 6 months of life?			
3. Did your child miss out the 'motor stage' of crawling on his or her tummy and creeping on hands and knees?			
4. Did your child have difficulty in learning to dress himself or herself, for example, do up buttons or tie shoelaces beyond the age of 6-7 years?			
5. Did your child suck his or her thumb beyond the age of 5 years?			
6. Did your child continue to wet the bed, albeit occasionally, above the age of 5 years?			
7. Did your child find it very difficult to learn to tell the time from a traditional (as opposed to digital) clock?			
8. Did your child have an unusual degree of difficulty learning to ride a bicycle?			
9. Does your child have difficulty catching a ball, doing forward rolls/somersaults and stand out as 'awkward' in PE classes?			
10. Does your child have difficulty sitting still for even a short period of time?			
11. If there is a sudden unexpected noise, does your child over-react?			

IV. Behaviors

Please rate the child on the following items. Place a number in the blank space to the left of the item that describes the child's school or home behavior.

1-Always 2-Frequently 3-Occasionally 4-Rarely 5-Never 6-Unknown

	Hyperactive		Poor ability to organize work
	Easily distracted		Indistinct speech
	Short attention span		Awkward or clumsy
	Easily frustrated		Poor peer group relationships
	Impulsive		Behavior problems
	Easily fatigued		Emotional problems

	Confusion after a series of verbal instructions
	Variable school performance (from hour to hour or day to day)
	Reverses letters, words, or numbers in reading
	Reverses letters, words, or numbers in writing
	Shows confusion about right, left, or other directional orientations

VIII. General History

Is there a history of **pregnancy or birth complication** (E.g. Caesarean Section, Forceps, etc.)? No Yes

If yes, please explain: _____

Was your child **born early or late** for term (more than 2 weeks early or more than 10 days late)? No Yes

Was your child's **birth weight** below 5lbs (pounds)? No Yes

In the **first 3 years** of life, did your child suffer from any **illnesses** involving extremely high temperatures, delirium or convulsion? No Yes

If yes, please explain: _____

Has there been any **severe childhood illness**, high fever, injury, or physical impairment? No Yes

If yes, please explain: _____

Did your child suffer from frequent **ear, nose, throat or chest infections** at any time? No Yes

If yes, please explain: _____

Does your child suffer from **travel sickness**? No Yes

Has the child received a **hearing test**? No Yes Date _____

Has a **hearing or speech deficiency** been previously diagnosed? No Yes Date _____

If yes, please explain: _____

Has the child received a complete **eye examination**? No Yes Date _____

Has a **visual problem** been diagnosed? No Yes

If yes, please explain: _____

Does the child have any **allergies**? No Yes

If yes, please explain: _____

Did your child have an adverse reaction to any of his or her **vaccinations**? No Yes

If yes, please explain: _____

Is the child taking any **medications** or pills? No Yes

If yes, please explain: _____

_____

Has the child previously taken **medication for attention deficit or hyperactivity**? No Yes

If yes, please list the medications, their purposes, and duration:

_____

_____

_____

V. School

	Yes	No	Unknown
1. Is your child having problems in school?			
2. Does your child like the teacher?			
3. Is the school satisfied with your child's performance?			
4. Are you satisfied with your child's performance?			
5. Do grades really show his or her abilities?			
6. Is there trouble completing written assignments?			
7. Does your child lose his or her place while reading?			
8. Does your child misread words that are known?			

VI. School Progress

Rate your child's progress in the following subjects:

1-Below grade level 2-Grade level 3-Above grade level

	Reading		Spelling		Writing		Arithmetic
	Art		Physical Education		Other?		

With what specific type(s) of work is your child having trouble? _____

_____

_____

Have other **family members** had difficulties learning any of the above subjects?

No _____ Yes _____ If yes, state relationship to child and subjects: _____

_____

Does your child have **memory difficulties**? No _____Yes _____ If so, what type of information:_____

_____

_____

IX. Therapy

Has there been any previous therapy for learning difficulties or visual or speech problems?

No ___ Yes___ If yes, please state the type of therapy, duration, and results:

_____

_____

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

INFORMATION RELEASE FORM

In order to enable collaboration between Orthovision Pte Ltd and the individuals listed below, **I give consent to the following exchanges of information pertaining to my child** (via email, phone calls or personal contact):

- ❑ The **staff/therapists at Orthovision Pte Ltd are given permission to share information about my child and the vision therapy treatment with the individuals** listed below.
- ❑ The **teachers/individuals listed below are given permission to share information with the staff of Orthovision Pte Ltd** which will help for the effective treatment of my child.
- ❑ Other: _____

This authorization is valid from _____ until

❑ this date _____

❑ 1 month after end of treatment

Comments:

_____

_____

_____

Contact of the teacher / school whom you give authority

School's Name_____

Grade _____

Teacher's Name _____

Phone_____

Other Staff (learning support teacher, counselor) _____

Teacher's E-Mail _____

Contact of other individuals / institution whom you give authority

Therapy Center_____

Child's Therapist _____ Phone _____

Therapist's E-Mail _____

Signature: _____ Date: _____

Name (print)