In order to provide the best possible care for your child, please answer the following questions. Thank you.

**Prenatal / Birth / Postnatal History**

01. Your child is: □ Natural □ Adopted □ Foster □ Other

02. What was the duration of your pregnancy? _______ weeks

03. Were there any problems during your pregnancy? □ Yes □ No

04. What was the type of delivery? □ Vaginal □ C-Section

05. How many days did your child spend in the hospital after delivery? ____________ days

06. Did your child need oxygen after delivery? □ Yes □ No

07. How many days did your child need oxygen after delivery? ____________________

08. Were there any complications immediately following the birth of your child? □ Yes □ No

09. Your child’s birth weight was: _________ lbs. __________ oz.

10. Your child’s APGAR score was (please circle)? 1 2 3 4 5 6 7 8 9 10

**Developmental History**

11. Did your child start sitting at approximately 5-8 months of age? □ Yes □ No

12. Did your child start crawling at approximately 5-8 months of age? □ Yes □ No

13. Did your child start walking at approximately 11-15 months of age? □ Yes □ No

14. Did your child start speaking at approximately 12-22 months of age? □ Yes □ No

15. Has your child been diagnosed with emotional disorders? □ Yes □ No

16. Has your child had uncommon childhood diagnoses or hospitalizations? □ Yes □ No

17. Is your child developmentally delayed? □ Yes □ No

18. Do you have other concerns about your child (i.e, ADHD, autism, etc.)? □ Yes □ No

19. Does your child have favorite toys, games, or songs? □ Yes □ No

20. Is your child fearful of certain things? □ Yes □ No

21. Did your child have any significant issues during their infant/toddler years? □ Yes □ No

22. Does your child have epilepsy and/or a history of seizures? □ Yes □ No

23. Do you wish to provide us with additional information about your child? □ Yes □ No
Previous Tests / Evaluations

24. Has your child had an IEP evaluation? □ Yes □ No
25. Has your child had a psycho-ed evaluation? □ Yes □ No
26. Has your child had a WISC IV/IQ evaluation? □ Yes □ No
27. Has your child had other tests or evaluations? □ Yes □ No

Previous Vision Care

28. Has your child ever worn eye glasses? □ Yes □ No
29. Has your child ever worn contacts? □ Yes □ No
30. Has your child ever worn an eye patch? □ Yes □ No
31. Has your child ever used atropine eye drops? □ Yes □ No
32. Has your child ever had an eye surgery? □ Yes □ No
33. Has your child ever taken other eye medications? □ Yes □ No
34. Has your child ever received vision therapy? □ Yes □ No

Academic History / Status (please answer the following questions if your child is in school)

35. What school does your child currently attend? _____________________________________________
36. Your child’s current grade in school? _____________________________________________________
37. Has your child ever repeated a grade in school? □ Yes □ No
38. In your opinion, what is your child's favorite subject? _______________________________________
39. In your opinion, what is your child's least favorite subject? ________________________________
40. What is your child’s reading level? □ Above Average □ Average □ Below Average
41. What is your child’s math level? □ Above Average □ Average □ Below Average
42. What is your child’s overall school performance? □ Above Average □ Average □ Below Average
43. Do you believe that your child is performing to their potential? □ Yes □ No
44. Is your child currently receiving occupational therapy? □ Yes □ No
45. Is your child currently receiving physical therapy? □ Yes □ No
46. Is your child currently receiving math tutoring? □ Yes □ No
47. Is your child currently receiving reading tutoring? □ Yes □ No
48. Is your child currently receiving vision therapy? □ Yes □ No

Signature of Patient or Legal Guardian  _____________________________________________________________
Print Name ________________________________________   Date  _____________________________________