Advanced Eyecare Specialists
www.aeswpb.com

Patient Information

Child's full name_______________________________________
Age__________Birthdate_______________________________
Is your child especially afraid of doctors? ☐Yes ☐ No

Parent Information

Father's Full Name_____________________________________
Home Address ☐ Same as patient address on Welcome Form
Address____
City __________________State _______Zip____________
Phone: H__________________ C______________________
E-mail____
Father's occupation____________________________________
Employer____
Work Phone____

Mother's Full Name____________________________________
Home Address ☐ Same as patient address on Welcome Form
Address____
City __________________State _______Zip____________
Phone: H__________________ C______________________
E-mail____
Mother's occupation___________________________________
Employer____
Work Phone____

Medical History

Most recent medical examination:
Doctor's name____
Date____
Results____
____
Medications currently using? _________________________
____
For what condition?___________________________________

Young Child History

Please bring this form to your child's appointment or return by email before the appointment. If your child has had other testing which Dr. Manes should be aware of, please provide a copy.

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
☐ Brain injury
☐ Other___________________________________
List illnesses, bad falls, head injuries, ear infections, high fever etc. (include complications and ages)
____
____
____
____
____
____
Is your child generally healthy?______________________
Are there any chronic problems like asthma, hay fever, allergies?____
If so, please list_______________________________________
____
____
____
Has a neurological evaluation been performed? ☐Yes ☐ No
By whom?____
Results____
____
____

Does your child currently receive:
Occupational therapy services? ☐ Yes ☐ No
By whom?____
Results____
____
Physical therapy services? ☐ Yes ☐ No
By whom?____
Results____
____
Speech therapy services? ☐ Yes ☐ No
By whom?____
Results____
____
Other therapy services? ☐ Yes ☐ No
Describe____

____

Nutritional Information

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Does your child crave sweets?________________________
Is your child: ☐ Moderately active ☐ Extremely active
Are there periods of high energy? ☐ Yes ☐ No
Low energy? ☐ Yes ☐ No

Developmental History

Full term pregnancy? ☐ Yes ☐ No Normal Birth? ☐ Yes ☐ No
Birth weight?________Was birth ___induced ___ c-section?
Any complications before, during, after or immediately following delivery?______________________________
Did your child crawl (stomach **on** floor)? ☐ Yes ☐ No
Age____
Did your child creep (stomach **off** floor)? ☐ Yes ☐ No
Age____
Did your child move on all fours? ☐ Yes ☐ No
Age____
If not describe__________________________________
____
At what age did your child walk?________________________
Was child active? ☐ Yes ☐ No
Speech: First words at age__________________________
Was early speech clear to others? ☐ Yes ☐ No
Is it clear now? ☐ Yes ☐ No
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: Doctor's name________________
____
Date____
Reason for examination____________________________
Results____
____
Were glasses prescribed? ☐ Yes ☐ No
Are they worn? ☐ Yes ☐ No ☐ Full-time ☐ Part-time
Comments______________________________________
Are eye exams done yearly? ☐ Yes ☐ No
List any other treatments or recommendations you have received regarding your child's vision:___________________
____
____
____

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

Name	Age	Visual Situation

Present Situation

Is there any concern from any other professional that some visual dysfunction may be present? ☐ Yes ☐ No
Describe_______________________________________
____
____
____
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_________________________________
____
____
____
____
____
____

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 of 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 playdough, clay, mudpies, fingerpaints, and cooking.

_______ Is excessively ticklish.
_______ Overreacts to physically painful experiences.
_______ Underreacts to physically painful experiences.
_______ 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?** ☐ 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 outings 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" kiddy 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 him/her self 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:____

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:____

14. **Do you feel that your child tends to be restless or "fidgety" during times when quiet concentration is required?**

☐ Yes ☐ No

Comments:____

General Behavior

Are there any behavior concerns? What causes theses concerns? ____

Family and Home

Please indicate which adults he/she lives with:

☐ Mother ☐ Father ☐ Step Mother ☐Step Father
☐ Foster Parents ☐ Adopted Parents ☐ Grandmother
☐ Grandfather ☐ Aunt ☐ Uncle
☐ Other________________________________

Siblings:	Names	Ages

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

Has he/she ever been through a traumatic family situation? (Such as divorce, parental loss, separation)

☐ Yes ☐ No

What age was he/she?____________________________

Does he/she seem to have adjusted?____________________

Is family life stable at this time? ☐ Yes ☐ No

How does he/she get along with parents?________________

Siblings?____________________________________

Classmates at school?____________________________

Playmates at home?______________________________

Give a brief description of your child as a person:__________
____

Report Policies

Would you like copies of any reports? ☐ Yes ☐ No

Would you like copies sent anywhere? ☐ Yes ☐ No

Name____

Address______________________________________

Name____

Address______________________________________

(For any others please use the back of this form)

Please sign below to give us permission to release information about your child to the above sources.

Signed_______________________________________

Date____