

VISION DEVELOPMENT INSTITUTE

Towne Centre Offices, 1789 S. Braddock Ave Pittsburgh PA 15218
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The information requested below is desired for the sole purpose of gaining an understanding of the applicant. Please answer all questions that are applicable as fully as possible and return this form to the above address. Your responses will remain confidential.

Applicant's Name _____

	Sex	Age	Birth Date
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Father	Phone (H)	(W)
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Mother	Phone (H)	(W)
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Home Address _____

City	State	Zipcode
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School Name and Address	Grade
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Who Referred You: _____

Specific Reason For Referral: _____

What do you want to find out from the exam: _____

Family History	Mother	Father
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Occupation: _____

Birth Place: _____

Marital Status: (dates)	Married	Married
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	Divorced	Divorced
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	Remarried	Remarried
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	Widow	Widower
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General Health: _____

	Mother	Father
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Highest Grade Completed: _____

Any Educational Difficulties:	Yes	No	Yes	No
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If yes, describe: _____

Language spoken in home: _____

Other Languages: _____

Brothers and Sisters	Oldest	Next Oldest	Next	Next
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Age	
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Sex	
-----	--

Grade Completed

Any Educational Difficulties? _____

If yes, describe: _____

DEVELOPMENTAL HISTORY

Is applicant adopted?	If yes, does applicant know this?	
Age when adopted?	Was pregnancy full term?	
Any complications before, after or during delivery?	If so, describe:	
Did the following occur later than the expected time?		
First Tooth	Creeping	Crawling
Sitting Alone	Walking Alone	Feeding Self
Voluntary control of Bladder	Toilet Training	
When did Child show tendency to establish handedness?		
Has anyone attempted to change applicant's handedness?		

MEDICAL HISTORY

Has child had any serious accidents, operations or unusual illnesses such as high-fever, prolonged confinement, etc. ? If so, please specify accidents and/or illnesses and the DATES they occurred:

Please state any existent allergies:

When was child's last physical examination? Any chronic problems?

Taking medication, if so what?

Has child been referred to neurologist? If so, for what reason?

Has child, or family been referred for counseling? If so, for what reason?

Was the therapy successful? Comment:

VISUAL HISTORY:

Has there been previous visual care?	If so, by whom and when?		
Were glasses prescribed?	Does child wear glasses without urging?		
Does child report headaches?	When?		
Does child report eyes "hurt/tired"?	When?		
Does child report blurred vision?	When?		
Does child report seeing "double"?	When?		
Does child report blur at distance?	When?		
Does child report blur at near/ reading?	When?		
Do bright lights bother child?	When?		
Are child's eyes frequently bloodshot?	When?		
Are there frequent Styes?	Which Eye?		
Does child rub his/her eyes?	When?		
Does child blink excessively?	When?		
Does child like to read?	Yes	No	
How much does child read?	Least	Most	

Does child reverse words or letters	Yes	No
Does child skip words or re-read	Yes	No
Does child move lips when reading to self:	Yes	No
Does child move head while reading?	Yes	No
Does child tilt head while reading?	Yes	No
Does child frown or squint at reading or TV?	Yes	No
Does child use finger to follow words?	Yes	No
Does child hold book too close while reading?	Yes	No
Does child read as well as others in same grade?	Yes	No

LANGUAGE DEVELOPMENT SKILLS:

At what age did child speak first sentence? (i.e. daddy hurt finger, mama kick ball) _____
 At what age did child ask first question? (i.e. mama doing ? ? ?) _____
 What was child's first "why?" _____ At what age? _____
 Does child have a speech or language deficit ? _____ If so has attempt been made to correct? _____
 By whom? _____
 Was the therapy successful? _____ Comments: _____

SLEEP PATTERNS:

Does child require a lot of sleep? _____
 Does child sleep soundly? _____
 What are the usual hours of sleep? From _____ to _____
 Does child awaken fresh and rested? _____
 Does fatigue result in sag, excitability or irritability? _____

EATING HABITS:

Is child a good eater ? _____
 Is intake low, medium or large ? _____
 Does your child take vitamin supplements? _____
 Describe: _____
 Is there a good variety of nutritious foods? _____
 Is there a high desire for sweets? _____
 Is there a high desire for 'junk foods' ? _____

FAMILY AND HOME SITUATIONS:

State any symptoms of anxiety such as nail-biting, eye blinking, or excessive eye rubbing, or tantrums, etc.

What type of discipline is most effective in guiding your child?

What adults besides the parents play an active part in guiding your child?

What responsibilities does your child have at home?

Can child carry out responsibilities alone? _____ Does child need reminders? _____

Does child have any outside job? _____ Paid or volunteer? _____ If so, what? _____

Describe the special interests of child: _____

SCHOOL ADJUSTMENT:

Please list the schools child has attended:

Name	Location	Grade Level

Indicate child's general achievement in school:

Grade Level	Very Poor	Poor	Average	Above Average

Does child like school? _____ Is attendance regular? _____

Has child ever been retained? _____ If yes, what grade(s)? _____

How did child react to retention? _____

What is the structure of the school (traditional or open classroom)? _____

Are there subjects that child likes more than others? If so, list: _____

Has child ever received special help in reading or math? _____

How do you feel your child performs in each of the following areas:

- _____ reading comprehension
- _____ reading retention
- _____ reading rate
- _____ spelling
- _____ handwriting
- _____ expressing thoughts verbally
- _____ expressing thoughts in writing
- _____ math concepts
- _____ math computation
- _____ attention span
- _____ ability to follow written directions
- _____ ability to follow verbal directions

Does child memorize answers or think through problems to obtain a solution?

What is child's general attitude toward present school and teachers? (likes, dislikes, indifferent, etc)

Type of teacher to whom child is most responsive? (i.e. male, female, strict, flexible)

How would you rate child's popularity among classmates? (ignored, rejected, accepted, has many friends of both sexes, etc.)

What age child does your child prefer to work and play with?

Older Same Younger What sex

Does the school consider your child to have a learning problem? Discuss:

PREVIOUS TESTING:

Type of testing:

Date(s) of testing:

Administered by whom?

Results or recommendations?

Does test taking appear to cause anxiety?

GENERAL MOVEMENT DEVELOPMENT:

Is child physically active?

List team sports:

List individual sports:

Can child throw a ball? Catch a ball?

Would you consider child to have good rhythm?

Is child "klutzy" or clumsy? Coordinated?

Do you consider child's general movement to be age appropriate?

BEHAVIORAL CHARACTERISTICS:

Following is a list of characteristics which can often be observed. Please circle the most appropriate response for each item as it relates to your child.

Blames others for troubles	Always	Usually	Rarely	Never	Don't Know.
Cries	Often	At Times	Rarely	Never	Don't Know
Daydreams	Often	At Times	Rarely	Never	Don't Know
Is friendly	Always	Usually	Rarely	Never	Don't Know
Gets in fights	Often	At Times	Rarely	Never	Don't Know
Is happy, light-hearted	Always	Usually	Rarely	Never	Don't Know
Must prod to get things done	Always	Usually	Rarely	Never	Don't Know
Follows through on tasks	Always	Usually	Rarely	Never	Don't Know
Listens to reason	Always	Usually	Rarely	Never	Don't Know
Is nervous, irritable	Always	Usually	Rarely	Never	Don't Know
Obeys	Always	Usually	Rarely	Never	Don't Know
Is honest	Always	Usually	Rarely	Never	Don't Know

