New Vision Eye Care and Rehabilitation Services

DEVELOPMENTAL/SENSORY HISTORY FORM

Patient's Name: _____DOB:_____ Date:_____

CHILD'S BIRTH, INFANCY, TODDLER YEARS:

	yes	No	Brief Explanation
1) Premature	____	____	_____
2) Full term	____	____	_____
3) Required forceps	____	____	_____
4) Had any birth injuries	____	____	_____
5) Any major birth complications	____	____	_____
6) Had insufficient oxygen	____	____	_____
7) Any other problems after birth	____	____	_____
8) Did your child crawl	____	____	Age:_____
9) What age did child walk			Age:_____
10) What age was child toilet trained			Age:_____
11) When did your child begin putting clothes on			Age:_____
12) When did your child begin buttoning clothes			Age:_____
13) When did child begin tying shoes			Age:_____

GENERAL INFORMATION:

Which hand does your child prefer to use?
_____

_____

Was handedness ever changed: If so explain
_____

_____

What are your child's special interests?
_____

_____

Give a brief thumbnail sketch of your child's personality:
_____
_____

Has your child had a neurological, psychological or educational evaluation performed? If
so by whom and the results: _____

_____

School Name: _____Grade:_____

_____

Yes No Brief explanation

Attends school regularly	___	___	_____
Likes school	___	___	_____
Likes teacher	___	___	_____
Child is working to potential	___	___	_____
Ever repeated a grade	___	___	_____
Had special tutoring or remedial work	___	___	_____
Changed schools often	___	___	_____
School seems overly stressful	___	___	_____
Loses place when reading	___	___	_____
Uses finger or marker	___	___	_____
Skips or omits words	___	___	_____
Rereads	___	___	_____
Reads out loud or lip reads	___	___	_____
Difficulty with comprehension	___	___	_____
Reverses letters or words	___	___	_____
Poor grades	___	___	_____
Poor handwriting	___	___	_____
Difficulty with spacing or sizing of letters	___	___	_____
Difficulty with left and right	___	___	_____
Easiest subject	___	___	_____
Most difficult subject	___	___	_____
TACTILE DEVELOPMENT:			
1) Child likes to be touched	___	___	_____
2) Dislikes being held or cuddled	___	___	_____
3) Prefers to touch rather than be touched	___	___	_____
4) Excessively ticklish	___	___	_____
5) Easily irritated or enraged when touched by others	___	___	_____
6) Has strong need to touch objects or people	___	___	_____
7) Avoids certain textures or food	___	___	_____
8) Objects to putting lotion on	___	___	_____
9) Picks fights frequently	___	___	_____
10) Pinches, bites, or hurts self or others	___	___	_____

11) Bumps into or pushes others ___ ___ _____
12) Bangs head on purpose ___ ___ _____
13) Dislikes the feeling of certain clothing ___ ___ _____
14) Overly sensitive to food or water temperature ___ ___ _____
15) Prefers baths over showers ___ ___ _____
16) Over or under dresses for the temperature ___ ___ _____
17) Does not like to play in water, sand, mud, etc ___ ___ _____
18) Lacks normal awareness of being touched ___ ___ _____
19) Often seems unaware of cuts, bruises, etc. ___ ___ _____
20) Examines objects with hands ___ ___ _____
21) Mouths objects or toys excessively ___ ___ _____

VESTIBULAR:

1) Arches back when held or moved ___ ___ _____
2) Enjoys or likes being rocked ___ ___ _____
3) Dislikes being tossed in air ___ ___ _____
4) Dislikes fast spinning rides ___ ___ _____
5) Dislikes to swing ___ ___ _____
6) Spins or whirls more than other children ___ ___ _____
7) Gets carsick easily ___ ___ _____
8) Gets nauseous or vomits from movement ___ ___ _____
9) Rocks while sitting ___ ___ _____
10) Jumps around a great deal ___ ___ _____
11) Has fear with stairs/heights ___ ___ _____
12) Loses balance easily ___ ___ _____
13) Walks on toes (not whole foot) ___ ___ _____

COORDINATION:

1) Seems clumsy ___ ___ _____
2) Bumps into objects ___ ___ _____
3) Sat, stood or walked late ___ ___ _____
4) Sat, stood or walked early ___ ___ _____
5) Careless ___ ___ _____
6) Frequently falls or trips ___ ___ _____
7) Creeping/crawling stage was omitted or very short ___ ___ _____
8) Dislikes trying new movement activities ___ ___ _____
9) Difficulty learning new movement activities ___ ___ _____
10) Has difficulty hopping, skipping or running ___ ___ _____
11) Difficulty with sequential tasks, buttoning, zipping, tying ___ ___ _____
12) Difficulty with rhythm or alternating movements ___ ___ _____
13) Avoids or has difficulty with sports activities ___ ___ _____
14) Difficulty with eye/hand

coordination ___ ___ _____

15) Difficulty manipulating small objects ___ ___ _____

16) Difficulty with pencil/crayon or cutting activities ___ ___ _____

17) Has rigid movements ___ ___ _____

18) Grimaces or uses tongue with fine motor tasks ___ ___ _____

MUSCLE TONE:

1) Feels heavier than looks ___ ___ _____

2) Poor standing posture ___ ___ _____

3) Poor sitting posture ___ ___ _____

4) Seems weaker than normal ___ ___ _____

5) Seems stronger than normal ___ ___ _____

6) Grasp is either too tight/weak ___ ___ _____

AUDITORY:

1) Has diagnosed hearing problem ___ ___ _____

2) Has tubes in ears ___ ___ _____

3) Frequent ear infections ___ ___ _____

4) Seems too sensitive to sounds ___ ___ _____

5) Responds to unexpected noise ___ ___ _____

6) Fears particular sounds ___ ___ _____

7) Distracted by sounds ___ ___ _____

8) Misses some sounds or words ___ _____

9) Fails to listen or pay attention to what is said ___ ___ _____

10) Confused what direction sounds come from ___ ___ _____

11) Likes to make loud noises ___ ___ _____

Yes No Brief explanation

12) Dislikes to sing or dance to music ___ ___ _____

BEHAVIOR:

1) Distractible ___ ___ _____

2) Difficulty concentrating ___ ___ _____

3) Difficulty completing a task ___ ___ _____

4) Frequent daydreaming ___ ___ _____

5) Feels inferior, poor confidence and self image ___ ___ _____

6) Depressed much of the time ___ ___ _____

7) Particularly shy, timid, fearful ___ ___ _____

8) Quite anxious, nervous or tense ___ ___ _____

9) Emotionally dependent orclinging ___ ___ _____

10) Gets mad easily (aggressive) ___ ___ _____

11) Frequent crying ___ ___ _____

Please be more specific in answering these questions than above:

Child is overly sensitive to sensory experiences more so than most people:

Yes_____ No_____ If yes circle all that apply

Auditory (noises)

Tactile (clothing textures, food, temperatures)

Movement (playgrounds, amusement parks, swings, etc)

Comments:

_____

Child doesn't seem to react to sensory experiences like other people:
Yes_____ No_____ If yes circle all that apply
Auditory (noises)
Tactile (clothing textures, food, temperatures)
Movement (playgrounds, amusement parks, swings, etc)
Comments:
_____

Child actively seeks out sensory experiences, more so than most people:
Yes_____ No_____ If yes circle all that apply
Auditory (noises)
Tactile (clothing textures, food, temperatures)
Movement (playgrounds, amusement parks, swings, etc)
Comments:_____

What are the presenting problems for your child currently?

Academic:
_____
_____

Sensory:
_____
_____

Motor:
_____
_____

Daily activities: (dressing, eating, playing):
_____
_____

Relationships: (difficulty playing with others, no friends, etc):
_____
_____

Thank you for carefully completing this questionnaire.
Would you like a report? _____To whom? Please sign your name, giving Dr. Michael L. Serrano, O.D., P.C. your authorization to send reports to the following:

Name:_____

Address:_____City:_____Zip:_____

Name:_____

Address:_____City:_____Zip:_____

Name:_____

Address:_____City:_____Zip:_____

I give Dr. Michael L. Serrano, O.D., P.C. permission to release information to the above people:

Name: _____ Date:_____