Hellerstein & Brenner
Vision Center, P.C.
Doctors of Optometry

Lynn Fishman Hellerstein, O.D., F.C.O.V.D., F.A.A.O.
Tricia Brenner, O.D.
Jina Schaff, O.D.

7180 E. Orchard Road, Suite 103
Englewood, CO 80111
(303) 850-9499

DEVELOPMENTAL HISTORY QUESTIONNAIRE

PATIENT'S NAME:_____ DATE_____

GENERAL INFORMATION:

Which hand does your child prefer to use?_____

Was handedness ever changed? Yes_____ No_____.
If yes, please explain_____
What are your child's special interests?_____
Give a brief thumb-nail sketch of your child's personality:_____
_____
Full term pregnancy:_____Normal birth?_____
Any complications before, during or immediately following delivery?_____
Did your child crawl?_____Age_____
At what age did your child walk?_____
At what age was your child toilet trained?_____
When did your child begin putting own clothes on?_____
When did your child begin buttoning his/her clothes?_____
When did your child begin lacing his/her own shoes?_____
Has your child had a neurological, psychological, or educational evaluation performed?_____
By whom?_____
Results?_____

School Name: _____ Grade_____	No	Yes	Comments
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 outloud or lip reads			
Difficulty with comprehension			
Reverses letters or words			

	No	Yes	Comments
Poor grades			
Poor handwriting			
Difficulty with spacing or sizing of letters			
Difficulty with left and right			
Easiest subject			
Most difficult subject			
<u>Coordination</u>			
Seems clumsy			
Bumps into objects			
Careless			
Frequently falls, trips			
Dislikes trying new movement activities			
Difficulty learning new movement activities			
Has trouble hopping, skipping or running			
Difficulty with rhythm or alternating movements			
Avoids or has difficulty with sports activities			
Difficulty with eye-hand coordination tasks			
Difficulty manipulating small objects			
Difficulty with pencil/crayon or cutting activities			
Difficulty with building			
<u>Muscle Tone</u>			
Poor standing posture			
Poor sitting posture			
Seems weaker than normal			
Seems stronger than normal			
Grasps objects too tightly			
Has weak grasp			
<u>Vestibular (Balance and Movement</u>			
Child overly active as a baby			
Overly active now			
Overly sensitive to going up or down inclines			
Overly sensitive to going fast			
Carsick			
Dislikes spinning or going in circles			
Prefers fast moving or spinning activities (rides, playground equipment)			
Avoids balance activities (i.e. monkey bars, playground activities, sports)			
Has poor balance			
<u>Tactile Sensation</u>			
Dislikes being touched or hugged pulls away in such situation			
Craves being touched or hugged			
Avoids certain textures or food			
Objects to putting on lotion			

	No	Yes	Comments
Speech			
Has difficulty understanding the meaning of what is said			
Difficulty in following directions			
Speech is sometimes unclear			
Poor use of grammar			
Quiet, talks very little			
Misses some sounds			
Has hearing loss			
History of chronic ear infection			
Overly sensitive to sounds			
Has a speech language evaluation ever been done?			
Has a hearing evaluation been done?___When?			
Has your child ever had speech therapy?			
Behavior			
Distractable			
Difficulty concentrating			
Difficulty completing a task			
Frequent daydreaming			
Feels inferior, poor confidence and self image			
Depressed much of the time			
Particularly shy, timid, fearful			
Quite anxious, nervous or tense			
Emotionally dependent or clinging			
Gets mad easily (aggressive)			
Frequent crying			
Nutritional information			
Currently has good diet			
Craves certain foods			
Eats a lot of sugar or food containing sugar			
Has periods of high or low energy			
Has allergies			

Thank you for carefully completing this questionnaire.
Would you like a report?_____To whom? Please sign your name, giving H&B Vision Center your authorization to send reports to the following:

Name _____
Address _____
_____
_____

Name _____
Address _____
_____

(Permission to release information by:)
Name: _____ Date: _____