



HELLERSTEIN & BRENNER  
VISION CENTER, P.C.

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**DEVELOPMENTAL/SENSORY HISTORY FORM**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent #1 Name: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Parent #2 Name: \_\_\_\_\_ Cell #: \_\_\_\_\_

**CHILD'S BIRTH, INFANCY, TODDLER YEARS:**

	<b>Yes</b>	<b>No</b>	<b>Brief Explanation</b>
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: \_\_\_\_\_

	<b>Yes</b>	<b>No</b>	<b>Brief explanation</b>
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	_____	_____	_____

	<b>Yes</b>	<b>No</b>	<b>Brief explanation</b>
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	_____	_____	_____

	<b>Yes</b>	<b>No</b>	<b>Brief explanation</b>
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	_____	_____	_____

	<b>Yes</b>	<b>No</b>	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 or clinging	_____	_____	_____
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:

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Sensory:

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Motor:

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Daily activities: (dressing, eating, playing):

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

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Thank you for carefully completing this questionnaire.

I give Hellerstein and Brenner Vision Center, P.C. authorization to send reports to the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Permission given by:

**Your Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I authorize Hellerstein and Brenner Vision Center to release and share information regarding my testing and or treatment program with the above listed professionals.