HELLERSTEIN & BRENNER
VISION CENTER, P.C.

TRICIA BRENNER, O.D. • SHELBY RILEY, O.D. • SARA GRELL, O.D. • KYARA FARINELLA, O.D. • AMY OVERLAND, O.D.

DEVELOPMENTAL/SENSORY HISTORY

If the patient is over 15 years of age, you may skip this questionnaire

Patient Name: ____

Parent/Guardian#1 Name	Cell #:	Email
Parent/Guardian#2 Name	Cell #:	Email

Birth/Developmental History:

☐ Premature ____
☐ Major Birth Complications ____
☐ Other Problems At Birth? ____
☐ Problems After Birth? ____
Development Delays: ☐ Crawling/Walking ☐ Talking ☐ Eating ☐ Grasping
☐ Other: ____

General/Academic:

School: ____
☐ Public ☐ Private/Charter ☐ Home School ☐ Hybrid Education
Grade: ☐ Preschool ☐ Kindergarten ☐ Grade Level ___________________________
☐Special Education ☐Gifted and Talented
☐ At Grade Level In All Subjects
☐ Below Grade Level In Some Subjects
☐ Math ☐ Reading ☐ Writing ☐ Other: ______________________________
☐Below In All Subjects
☐Repeated Grade? ____
☐Current tutoring/remedial services ____
☐ Math ☐ Reading ☐ Writing ☐ Other ________________________________
☐ IEP/ILP ☐504 ☐ Other Accommodations/Supports
☐ SLT ☐ OT ☐ Behavioral ☐ Small Group Support
If **YES:**
Therapist (Name/Clinic): ____
Date Started: _____________ Frequency: ☐ Weekly ☐ Biweekly
☐Other: ____
☐Avoids/dislikes school or homework

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☐History of Neurological/Academic/Behavioral Testing?
If **YES:**
Provider (Name/Clinic): ____
Date: ____________ Testing: ____

☐ **Reading Challenges**
☐ Loses place/skips words/skips lines ☐ Difficulty reading out loud
☐ Difficulty with letter/number recognition or identification
☐ Uses finger/marker to keep place ☐ Difficulty with phonics
☐ Rereads ☐ Difficulty with memory ☐ Difficulty with spelling
☐ Difficulty with comprehension ☐ Difficulty with fluency
☐ Diagnosed with dyslexia or other learning disability
Other: ____

☐ **Writing Challenges**
☐ Illegible/messy ☐ Poor spacing/letter sizing ☐ Irregular pencil grip
☐ Diagnosed with dysgraphia ☐ Letter reversals ☐ Writing out of order
☐ Skipping words ☐ Writing off line of paper
Other: ____

☐ **Sensory Concerns/Challenges**
Overly Sensitive To:
☐ Touch ☐ Textures ☐ Smells ☐ Sounds ☐ Foods ☐ Lights ☐ Change
Diagnoses:
☐ Auditory processing disorder (APD)
☐ Sensory processing disorder
☐ Visual processing disorder
Other: ____

☐ **Behavioral Challenges**
☐ Stress/anxiety/overwhelm ☐ Shy/timid/fearful
☐ Depression avoidance ☐ Poor attention ☐ Anger/frustration
☐ Aggression/violence ☐ Self-harm ☐ Avoidance ☐ Poor attention
☐ Other: ____

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Common Pediatric Diagnosis

☐ ADD/ADHD ☐ Down Syndrome ☐ Autism Spectrum Disorder (ASD)
☐ Anxiety/depression
Other: (not listed on general medical history)
____

Balance/Coordination

☐ Bumping into things ☐ Disoriented easily ☐ Falling/tripping
☐ Difficulty with navigation ☐ Difficulty with ball play
☐ Poor eye-hand coordination/eye-foot coordination
☐ Active in sports ☐ Avoids physical activity/sports
Other: ____

Vestibular Challenges

☐ Motor/car sickness ☐ Dizziness ☐ Nausea/vomiting
☐ Leaning/drifting/poor walking posture
Other: ____

Motor Challenges

☐ Fine motor challenges? ____

☐ Gross motor challenges? ____

☐ History of physical therapy
Muscular Disorders
☐ Cerebral Palsy ☐ Multiple sclerosis ☐ Muscular dystrophy
☐ Myasthenia Gravis ☐ Other: _________________________________

Auditory Challenges

☐ Hearing issues ☐ Auditory/processing issues (APD)
☐ Sound sensitivity ☐ Difficulty with verbal instructions ☐ Frequent ear infections
☐ Other: ____

Comments:
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