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**Developmental Questionnaire**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Father's Name \_\_\_\_\_ Phone: \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_  
Home Address \_\_\_\_\_

Reason for Referral \_\_\_\_\_  
Referred by \_\_\_\_\_  
What do you want to find out from the exam? \_\_\_\_\_

**Family**

1. Father: occupation \_\_\_\_\_ marital status \_\_\_\_\_ grade completed \_\_\_\_\_
2. Mother: occupation \_\_\_\_\_ marital status \_\_\_\_\_ grade completed \_\_\_\_\_
3. Languages spoken in home \_\_\_\_\_
4. Siblings (age and sex) \_\_\_\_\_

**Developmental History**

1. Is the child adopted? \_\_\_\_\_ If yes, does the child know? \_\_\_\_\_ Age when adopted? \_\_\_\_\_
2. Was pregnancy full term? \_\_\_\_\_ Child's weight at birth \_\_\_\_\_
3. Complications before, during, following delivery? \_\_\_\_\_
4. Was child exposed to: \_\_\_\_\_ drugs in utero \_\_\_\_\_ alcohol \_\_\_\_\_ nicotine \_\_\_\_\_
5. At what time did the following occur:  
creeping (stomach off floor) \_\_\_\_\_ crawling (stomach on floor) \_\_\_\_\_ sitting alone \_\_\_\_\_  
walking alone \_\_\_\_\_ feeding self \_\_\_\_\_ voluntary bladder control \_\_\_\_\_  
tendency to show handedness \_\_\_\_\_
6. Has anyone attempted to change child's handedness? \_\_\_\_\_

**Medical History**

1. Has your child had any serious accidents, operations or unusual illnesses? If so, please specify.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. List any allergies \_\_\_\_\_
3. Medications/vitamins currently being used: \_\_\_\_\_
4. Last medical exam \_\_\_\_\_  
What were the recommendations? \_\_\_\_\_  
Name of Pediatrician \_\_\_\_\_  
Does test taking appear to cause anxiety? \_\_\_\_\_
6. Has your child or family been referred for counseling? \_\_\_\_\_  
If so, what was the reason for referral \_\_\_\_\_  
Was the therapy successful? \_\_\_\_\_

**Vision Care**

Last eye exam \_\_\_\_\_ Location/ Doctor \_\_\_\_\_  
Does your child currently wear eyeglasses? \_\_\_\_\_ If yes, how old are they? \_\_\_\_\_  
Has your child been treated with a patch or eye drops for Amblyopia? \_\_\_\_\_  
If yes, describe the treatment plan \_\_\_\_\_

Has your child reported any of the following:

- Headaches If yes, when \_\_\_\_\_
- Blurred vision \_\_\_\_\_
- Tired eyes \_\_\_\_\_
- Double vision \_\_\_\_\_
- Light sensitivity \_\_\_\_\_

Have you noticed any of the following while observing your child?

- Squinting
- Close/cover one eye
- Eye rubbing
- Excessive blinking
- Reverses words/letters
- Skips words or rereads
- Moves lips while reading quietly
- Moves head while reading
- Tilts head while reading
- Loses place when reading
- Writes or prints poorly
- Difficulty copying from blackboard
- Tires when reading/doing homework
- Eye turning inward/outward  
If so, one eye or both, distance or near
- Hold his/her book too close while reading

### General Development Skills

1. At what age did your child:  
Speak first sentence \_\_\_\_\_ Ask first questions \_\_\_\_\_
2. Was there another method of communication prior to speech? \_\_\_\_\_
3. Does your child have a speech or language deficit? \_\_\_\_\_
4. Has your child had speech therapy? \_\_\_\_\_
5. Has your child had physical therapy? \_\_\_\_\_ Occupational therapy? \_\_\_\_\_  
Was therapy successful? \_\_\_\_\_

### General Health

1. Does your child sleep through the night? \_\_\_\_\_
2. Current hours of sleep per night? \_\_\_\_\_
3. Does your child have a good diet? \_\_\_\_\_
4. Does your child eat fruit and vegetables? \_\_\_\_\_
5. Does your child take vitamin supplements? \_\_\_\_\_
6. Is there a high desire for sweets or junk food? \_\_\_\_\_
7. Are there any food allergies? \_\_\_\_\_ If yes, please list \_\_\_\_\_
8. Is your child on a restricted diet? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

### Family and Home

1. What responsibilities does your child have at home? \_\_\_\_\_
2. Can your child carry out these responsibilities independently? \_\_\_\_\_
3. Describe special interests/hobbies: \_\_\_\_\_
4. State any tensional behavior such as nail biting, eye blinking, excessive eye rubbing, tantrums or tongue chewing \_\_\_\_\_
5. What discipline is most effective in guiding your child? \_\_\_\_\_
6. What adults besides the parents plan an active part in guiding your child? \_\_\_\_\_

**School Information**

Please list the schools your child has attended, beginning with the current school (including home school)

Name	Location	Grade Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Does your child like school? \_\_\_\_\_ Is their attendance regular? \_\_\_\_\_

2. Has your child ever been retained? \_\_\_\_\_ If yes, what grade? \_\_\_\_\_  
How did your child react to retention? \_\_\_\_\_

3. What is the structure of the school (traditional, open classroom, etc) \_\_\_\_\_

4. Which subject does your child enjoy the most? \_\_\_\_\_

5. How do you think your child performs in the following areas:

Reading comprehension	very good	adequate	fair	inadequate	poor
Sight vocabulary	very good	adequate	fair	inadequate	poor
Reading speed	very good	adequate	fair	inadequate	poor
Spelling	very good	adequate	fair	inadequate	poor
Handwriting	very good	adequate	fair	inadequate	poor
Expressing thoughts verbally	very good	adequate	fair	inadequate	poor
Expressing thoughts through writing	very good	adequate	fair	inadequate	poor
Math concepts	very good	adequate	fair	inadequate	poor
Attention span	very good	adequate	fair	inadequate	poor
Ability to follow written directions	very good	adequate	fair	inadequate	poor
Ability to follow verbal directions	very good	adequate	fair	inadequate	poor

6. Does your child memorize answers or does she/he think through a problem to obtain the solution?  
\_\_\_\_\_

7. What is your child’s general attitude towards present school teachers? \_\_\_\_\_

8. What is your child’s attitude towards teachers in general? \_\_\_\_\_

9. Type of teacher to whom your child is most responsive (i.e. make, female, strict, flexible):  
\_\_\_\_\_

10. How would you rate your child’s popularity among his/her classmates (ignored, rejected, accepted):  
\_\_\_\_\_

11. Does the school consider your child to have a learning problem? \_\_\_\_\_ Discuss:  
\_\_\_\_\_

12. Does the school consider your child to have a discipline problem? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

13. Has your child had any previous testing done at the school level? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

14. Does your child like to read? \_\_\_\_\_ If yes, what types of materials? \_\_\_\_\_

15. Does your child read as well as expected? \_\_\_\_\_

**General Movement**

1. Is your child physically active? \_\_\_\_\_

2. List team sports: \_\_\_\_\_

3. List individual sports: \_\_\_\_\_

4. Can your child catch a ball? \_\_\_\_\_ Throw a ball? \_\_\_\_\_

5. Would you consider your child to have good rhythm? \_\_\_\_\_  
Is your child clumsy? \_\_\_\_\_ Is your child coordinated? \_\_\_\_\_

6. Does your child avoid sports? \_\_\_\_\_

**Behavioral Characteristics**

The following is a list of characteristics that can often be observed in children. Please circle the appropriate response as they apply to your child.

Cries	most often	sometimes	rarely	unknown
Daydreams	most often	sometimes	rarely	unknown
Is friendly	most often	sometimes	rarely	unknown
Gets in fights	most often	sometimes	rarely	unknown
Is happy, light-hearted	most often	sometimes	rarely	unknown
Interacts well with adults	most often	sometimes	rarely	unknown
Has to be prodded to get things done	most often	sometimes	rarely	unknown
Follows through on tasks	most often	sometimes	rarely	unknown
Listens to reason	most often	sometimes	rarely	unknown
Nervous, irritable	most often	sometimes	rarely	unknown
Obeys	most often	sometimes	rarely	unknown
Is honest	most often	sometimes	rarely	unknown
Talks back	most often	sometimes	rarely	unknown
Temper tantrums	most often	sometimes	rarely	unknown
Timid, shy	most often	sometimes	rarely	unknown
Has strong fears	most often	sometimes	rarely	unknown
Becomes frustrated	most often	sometimes	rarely	unknown
Is dominated by other children	most often	sometimes	rarely	unknown
Takes lead with peers	most often	sometimes	rarely	unknown
Plays with children of same age	most often	sometimes	rarely	unknown
Plays with children of older age	most often	sometimes	rarely	unknown
Plays with children of younger age	most often	sometimes	rarely	unknown

Are any of the above behaviors significantly different at home vs. school?

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Please describe any other characteristics of your child that we should be aware of in order to meet his/her needs as fully as possible.

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*❖ Did you answer all four pages? Thank you*

Signature \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Date \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_  
 Address: \_\_\_\_\_ Last Eye Doctor: \_\_\_\_\_  
 City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_  
 Phone Number: (h) \_\_\_\_\_ (w) \_\_\_\_\_ Current Medical Dr.: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Vision Insurance Plan: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
 Member ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Medical History**

Do you have any allergies to medications?  Yes  No If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Are you pregnant and/or nursing?  Yes  No If yes, explain: \_\_\_\_\_  
 Have you had any eye surgeries?  Yes  No If yes, explain: \_\_\_\_\_  
 Have you ever had vision therapy?  Yes  No If yes, explain: \_\_\_\_\_  
 Have you ever injured your eyes?  Yes  No If yes, explain: \_\_\_\_\_  
 Do you wear glasses?  Yes  No If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Do you wear contact lenses?  Yes  No If yes, how old is your present pair or lenses? \_\_\_\_\_  
 Type of contact lenses:  Rigid  Soft  Extended Wear  Other \_\_\_\_\_  
 Name of lenses: \_\_\_\_\_ Are they comfortable? \_\_\_\_\_

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas:

Visual System	current	past	never	Systemic System	current	past	never
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urogenital (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (Anemia, cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological (MS, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (acne, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (depression, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(asthma, bronchitis, emphysema)			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

*Please fill out the back side...*

**Social History**

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  None

What type of work do you do? \_\_\_\_\_

Do you go to school?  Yes  No If yes, where and grade level/field of study? \_\_\_\_\_

Do you play any sports?  Yes  No If yes, type and amount: \_\_\_\_\_

Other forms of exercise? \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_

How many hours per day do you:

Work on a computer? \_\_\_\_\_

Read? \_\_\_\_\_

Watch TV? \_\_\_\_\_

Play video games? \_\_\_\_\_

**Family History**

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Systemic Disease/Condition	Yes	No	Not Sure	Relationship to you
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				_____

*Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventive and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:*

- Fees for services are due at the time those services are rendered.
- A deposit is required on all materials and balance due upon delivery.
- We reserve the right to charge for missed appointments not cancelled in advance.
- Visual training patients must notify us of absences in advance.
- There is a charge for written reports.
- Responsibility for payment is the patient's. Insurance agreements are between company and patient. We will assist with proper forms but require reimbursement from patients.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_