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We ask that you fill out the following questionnaire as completely as possible. The information will help us plan for the evaluation and to ascertain your child's needs most effectively. Please return the questionnaire to us when it is completed, but prior to the exam.

Date _____

I. CHILD'S INFORMATION

Name: _____
Last First Middle Called by

Birth Date: _____
Month Day Year Time City, State

Age: _____ Sex: _____
Year Month

Address: _____
Street and No. City State Zip

Phone: _____

II. PARENT AND FAMILY INFORMATION

Father's Name: _____ Birth Date: _____

Address: _____ Phone: _____
(if different from child's)

Business Name: _____ Occupation: _____

Bus. Address: _____ Phone: _____

Mother's Name: _____ Birth Date: _____

Address: _____ Phone: _____
 (if different from child's)

Bus. Address: _____ Occupation: _____

Address: _____ Phone: _____

Guardian: _____ Birth Date: _____

Address: _____ Phone: _____
 (if different from child's)

Business Name: _____ Occupation: _____

Bus. Address: _____ Phone: _____

Marital Status of Parents:

	Mother	Family Structure	Father
<input type="checkbox"/> Married	<input type="checkbox"/>	Natural Parent	<input type="checkbox"/>
<input type="checkbox"/> Separated or Divorced	<input type="checkbox"/>	Adopted Parent	<input type="checkbox"/>
<input type="checkbox"/> Father deceased	<input type="checkbox"/>	Foster Parent	<input type="checkbox"/>
<input type="checkbox"/> Mother deceased	<input type="checkbox"/>	Other/Specify	<input type="checkbox"/>

Parent's Education:

Levels Completed	Mother	Father
Grade School	<input type="checkbox"/>	<input type="checkbox"/>
High School	<input type="checkbox"/>	<input type="checkbox"/>
College or Equivalent	<input type="checkbox"/>	<input type="checkbox"/>
Graduate/Professional	<input type="checkbox"/>	<input type="checkbox"/>

Ordinal Position of Child (i.e. 3rd or 6 = 3/6) _____

Siblings:

Name	Age	Adopted		Difficulty in School	
		Yes	No	Yes	No
_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of household moves in child's lifetime: _____

Family history to three generations: If yes, please specify relationship

	Yes	No	Relationship
Multiple births	()	()	_____
Hereditary diseases	()	()	_____
Neuropsychiatric disorders	()	()	_____
Left-handedness	()	()	_____
Speech difficulty	()	()	_____
Reading and writing difficulty	()	()	_____
Hyperactivity	()	()	_____
Bilingual parent	()	()	_____
Language spoken in home: _____			
Visual problems	()	()	_____
Auditory problems	()	()	_____
Diabetes	()	()	_____
Epilepsy	()	()	_____
Asthma	()	()	_____
Allergies	()	()	_____
List: _____			

PRESENT SITUATION

Reason for evaluation: _____

Have you noticed any difference in this child compared to other children (brothers, sisters, playmates, etc.)?

When? _____

Who first noticed the child's problems? _____

When? _____

Did the problem occur suddenly? _____

Do his/her problems seem to be related to illness, accident, or other trauma?

PRE-NATAL MEDICAL HISTORY

	Yes	No
Miscarriages or still born prior to this child	()	()
Any deaths before age 1?	()	()
Blood incompatibility (RH)	()	()
Toxemia (blood Poisoning)	()	()
Measles	()	()
Major illness or trauma	()	()
Spotting or bleeding	()	()
Pelvic X-rays	()	()
Hemorrhage	()	()
Barbiturates	()	()
Hallucinogenic/Illicit Drugs	()	()
Active during pregnancy	()	()
High blood pressure	()	()
Diabetes	()	()
Excessive Alcohol	()	()
Poor nutrition during pregnancy	()	()
Was child active in utero?	()	()

Usage of internal medications () ()
 List _____

Other abnormalities: () ()
 List _____

LABOR AND DELIVERY HISTORY

Length of pregnancy _____ Birth weight ____lbs. ____ oz.
 Forceps ____ Breech ____ Caesarean ____ Natural ____

	Yes	No
Labor spontaneous/No complications	()	()
Crying immediately	()	()
Good color	()	()
Exchange transfusion	()	()
Severe jaundice	()	()
Anoxia (lack of oxygen)	()	()
Resuscitation	()	()
Incubator	()	()
Seizures	()	()
Nursing	()	()
Formula	()	()
Poor sucking	()	()
Abnormal cry	()	()
Regular sleep	()	()
Other	()	()

List _____

CHILD'S EARLY MEDICAL HISTORY

	Yes	No	Age
Past illness	()	()	_____
Head trauma with consciousness	()	()	_____
Convulsions or seizures	()	()	_____
Diabetes	()	()	_____
Encephalitis	()	()	_____
Rheumatic Fever	()	()	_____
Asthma	()	()	_____
Measles (severe)	()	()	_____
High fever	()	()	_____
Serious infection	()	()	_____
Reactions to drugs or vaccines	()	()	_____
Ear infections	()	()	_____
Colic	()	()	_____
Vaccines	()	()	_____
Respiratory infections	()	()	_____

	Yes	No
Is the child currently taking medication?	()	()
List _____		
What purpose? _____		

Past medications?	()	()
List _____		

DEVELOPMENTAL HISTORY

	Yes	No	Age
Is your child active?	()	()	
Is speech clear to others?	()	()	
Has child worn any type of cast/crutches?	()	()	
Hearing problems?	()	()	
What hand does child use for most tasks?	_____		
Which foot is used for kicking?	_____		

At what age did your child walk?	_____
Speech: First words at what age?	_____

Did your child crawl?	()	()	_____
All fours? ____ If not, please describe _____			

BEHAVIORAL CHARACTERISTICS

	Yes	No	Comments:
Head banging	()	()	
Temper tantrums	()	()	
Eating dirt or other non-edibles	()	()	
Motion Sickness	()	()	
Teeth grinding	()	()	

Stubborn	()	()
Upset easily	()	()
Impulsive	()	()
Fails to plan for homework	()	()
Does not finish tasks	()	()
Disorganized, messy work	()	()
Shy, bashful	()	()
Disobedient	()	()
Negative attitude	()	()
Lacks enthusiasm	()	()
Sucks thumb	()	()
Irregular sleeping habits	()	()
Difficulty falling asleep	()	()
Elimination irregular	()	()
Whines/pouts to get his/her way	()	()
Nail biting	()	()
Required constant discipline	()	()
Manipulates others/gets them to do things	()	()
Moods up and down with good reason	()	()
Seeks excessive attention	()	()
Feelings easily hurt	()	()
Fighting, hot tempered	()	()
Uncooperative	()	()
Destructive	()	()
Does your child get along with:		
Parents?	()	()
Siblings?	()	()
Classmates?	()	()
Playmates?	()	()
Involved in excessive TV watching	()	()
Cannot sit still/In constant motion	()	()

SCHOOL HISTORY

	Yes	No
Discipline problem at school	()	()
Child likes school	()	()
Child likes to read	()	()
Repeated grades	()	()
Extreme pressure at school	()	()
Special tutoring or remedial assistance	()	()
Confuses letters/words	()	()
Reverses letters/words	()	()
Skips or re-reads	()	()
Vocalizes when reading silently	()	()
Reads slowly	()	()
Uses finger as a marker	()	()
Poor reading comprehension	()	()
Moves head excessively when reading	()	()
Writes/Prints poorly	()	()

Comments:

Tires easily	()	()
Inattentive/Daydreams/Withdrawn	()	()
Avoids near tasks	()	()
Above average school work	()	()
Below average school work	()	()
Tilts head when reading	()	()
Poor posture when reading	()	()
Loses place when reading	()	()

VISUAL HISTORY

	Yes	No	Comments:
Closes one eye frequently	()	()	
Covering one eye frequently	()	()	
Red eyes	()	()	
Excessive eye rubbing	()	()	
Large pupils in normal light	()	()	
Bothered by light	()	()	
Bumps into objects	()	()	
Excessive blinking	()	()	
Frequent styes	()	()	
Problem seeing the school board	()	()	
Squinting	()	()	
Eyestrain or headaches	()	()	

Please list typical food intake....the type and quantity for one day.

Breakfast:

Lunch:

Dinner:

Snacks:

Please add any additional comments or information on the reverse side. Also, please request copies of all prior evaluation reports be sent to us prior to the evaluation date to complete our history of your child.

SIGNATURE: _____