FAMILY VISION CARE OPTOMETRY

Supplemental Form – PRE-SENSORY LEARNING PROGRAM

Please fill out this questionnaire *carefully* and as thoroughly as possible prior to starting the Sensory Learning Program. There are a total of 6 pages – please be sure you have completed all six pages. THANK YOU.

Date: _____

Patient's Name: _____ Male ☐ Female ☐

1. Physical Aspects

☐ Repetitive rounds of antibiotics?
☐ Child appears not to feel pain?
☐ Difficulty with toilet-training?
☐ Tactile defensiveness (clothing tags, food texture)?
☐ Any regression after immunizations?
☐ Are there any digestion/elimination problems?
☐ Difficulty with fine motor skills (eating with utensils, using crayons)?
☐ Can child pedal or ride a 2-wheeler?
☐ Irregular sleep patterns?
☐ Issues with bed-wetting?
☐ Appears clumsy or uncoordinated?
☐ Any detoxifying or chelating procedures?
☐ Is dietary modification in place?

2. Visual/Motor Skills

☐ Poor eye contact?
☐ Tracking Problems?
☐ Sideways gazing?
☐ Strabismus?
☐ Is artwork too primitive for child's age?
☐ Difficulty catching a ball?

3. Auditory/Language

☐ Was there a speech delay?
☐ Are there 'central auditory processing' issues?
☐ Sensitivity to sounds (blender, hair dryer, vacuum)?
☐ Is speech now age-appropriate?
☐ Does child have a sense of rhythm?

4. Behavioral Responses to Sensory Stimuli

☐ Overwhelmed in sensory-rich environments?
☐ Under responsive to sensory stimuli?
☐ Mesmerized by lights or fans?
☐ Addictive tendencies to TV/Computer games?
☐ Obsesses with routines and/or repetitive patterns?
☐ Hyperactive?
☐ Any 'self-stimming' behaviors present?
☐ Hand-flapping?
☐ Toe-walking?
☐ Difficulty with transitions?

5. Emotional Responses to Sensory Stimuli

☐ Difficulty showing affection?
☐ Has unreasonable fears?
☐ Angry and/or aggressive behavior?
☐ Often Depressed?
☐ Controls environment and manipulates people?
☐ Difficult relationships with peers?
☐ Child feels he/she has no friends?
☐ Shows lack of empathy?
☐ Has frequent meltdowns/tantrums?
☐ High Anxiety?
☐ Night Terrors?
☐ Has extreme shyness?
☐ Missing social cues?
☐ Frequently teased by peers?

6. Academic, Visual/Auditory Skills

☐ Difficulty making progress with handwriting?
☐ Difficulty following multi-step oral directions?
☐ Can child decode phonetically (sound out words)?
☐ Difficulty understanding symbols (shapes, numbers, letters, etc.)?
☐ Difficulty learning to read?
☐ Can child learn spelling words easily?

Neuro Vision Rehabilitation Institute
(Division of Family Vision Care Optometry, Inc.)

Drs. Carl Garbus, James Yi,
Andrea Woo & Mariya Berkovich
28514 Constellation Road
Valencia, CA 91355
Phone: 661 775-1440
Website: FVCOptometry.com

PRE-SESSION

SENSORY LEARNING[SM] PROFILE

This information will be treated confidentially.

Patient Name: _____ Date: _____

We would like this form to give us a present overall picture of the patient as they are beginning the Sensory Learning[SM] Program so that we can best conduct the program.

Contact Information

Contact's Name: _____ Relationship: _____

Address: _____

City: _____ Zip: _____

Phone: _____ E-mail: _____

Patient Date of Birth: _____

Please tell us about where your speech and language development is currently. (i.e. non-verbal, articulation issues, conversational skills, etc)

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SENSORY LEARNING[SM] PROFILE

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Please describe any present auditory issues. (i.e. sensitivities, receptive language skills, understanding verbal multi-step directions, etc)

Please describe any present visual issues. (i.e. light sensitivity, eye tracking problems, glasses/ contacts, quality of eye contact, etc)

Please describe present vestibular/ motor issues. (i.e. low muscle tone, poor balance, gravitationally insecure, tactile defensiveness, poor coordination, etc)

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SENSORY LEARNING[SM] PROFILE

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Please describe any history of events that you feel are affecting your abilities today. (i.e. hospitalizations, surgeries, injuries, traumas, accidents/falls, etc)

Current Health Concerns

Diabetic: _____

_____

Epilepsy: _____

_____

Food Allergies: _____

_____

Other: _____

_____

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Please share any current medications that you're taking?

Please describe your overall behavior. (i.e. overwhelmed easily, aggressive tendencies, frequent tantrums, ability to express emotion, obsession with routine and repetitive patterns, hyper active, etc)

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SENSORY LEARNING℠ PROFILE

This information will be treated confidentially.

Hopes-for benefits before participation in the Sensory Learning ™ Program

Please elaborate in the following areas:

1. Activity Level/Sleep Patterns:
2. Sensory Integration/Motor Skills:
3. Speech/Language Skills:
4. Perceptual/Cognitive Skills:
5. Personal/Social Skills:
6. Emotional/ Behavioral Changes:

Additional comments-