SCHOOL AGE CHILD HISTORY

Developmental Vision & Rehabilitation

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Date

General Information

Child's Full Name ______________________
Age __________ Birthdate ______________
School ______________________
School Address ______________________
Grade______ Teacher ______________
Principal ________ Referred by ______________
Is your child especially afraid of doctors? ________

Family Information

Father ______________________
Birthdate ______________________
Mother ______________________
Birthdate ______________________
Brothers: Birthdates:
____
____
Sisters: Birthdates:
____
____

Parent Information

Home address ______________________
City______________ State______ Zip______
Home phone ______________________
Cell phone ______________________
Fax number ______________________
Email ______________________
Father's occupation ______________________
Employer ______________________
Work phone ______________________
Mother's occupation ______________________
Employer ______________________
Work phone ______________________
Do you have a health care plan? ______________
If so, name of health care plan? ______________
Policy number ______________________

Medical History

Most recent medical examination ______________
Doctor's name ______________________
Date ______________________
Results ______________________
____
____
Medications currently using ______________
____
For what condition? ______________________
Any history in your family of the following?

- ☐ Glaucoma
- ☐ High blood pressure

Has your child been diagnosed as having:

- ☐ Learning disabilities
- ☐ Developmental delays
- ☐ ADD or ADHD
- ☐ Cerebral Palsy
- ☐ Seizure disorders
- ☐ Autism

Other problems ______________________
List illnesses, bad falls, head injuries, high fevers etc.
____
____
____
Concussions & when:
____
____
Complications & ages:
____
____
Is your child generally healthy? ______________
Are there any chronic problems like asthma, hay fever, allergies, ear infections? ______________
If so, please list: ______________________
____
____
Has a neurological evaluation been performed? ____
By whom? ______________________
Results: ______________________
____
Has a psychological evaluation been performed? __
By whom? ______________________
Results: ______________________

Does your child currently receive:

Occupational therapy services? ________________
By whom? ________________
Results: ________________
____
____

Physical therapy services? ________________
By whom? ________________
Results: ________________
____

Speech therapy services? ________________
By whom? ________________
Results: ________________
____

Other therapy services? ________________
By whom? ________________
Results: ________________
____

Nutrition

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Does your child crave sweets? ________________
Is your child: ☐ Moderately active ☐ Extremely active
Are there periods of very high energy? ________________
Low energy? ________________
Has your child had any allergy testing? ________________
When? ________________
By whom? ________________
Results: ________________
____
____
Does your child have any food sensitivities? ________________
Does your child take any vitamins or supplements? ________________

Developmental History

Full term pregnancy? ________ Normal Birth? ________
Birth weight? ________________
Any complications before, during or immediately following delivery? ________________
Did your child crawl (stomach on floor)? ________________
Age: ________________
Did your child creep (stomach off floor)? ________________
Age: ________________
Did your child move on all fours? ________________
Age: ________________
If not describe: ________________
At what age did your child walk? ________________
Was child active? ________________

Developmental History (continued)

Speech: First words at age: ________________
Was early speech clear to others? ________________
Is it clear now? ________________
Any history of crossing eyes? ☐ Yes ☐ No
What age first noticed: ________________
Any family history of crossing eyes? ☐ Yes ☐ No
Who? ________________

Visual History

Previous Eye Examination:
Doctor's name: ________________
Date: ________________
Reason for examination ________________
____
Results: ________________
Were glasses prescribed? ________________
Are they worn? ________________
When? ________________
Members of the family who have had visual attention and why:

Name	Age	Visual Situation

Present Situation

Is there any evidence from school or psychological tests that some visual malfunction may be present?
____
____
If so, what? ________________
____
____

Does your child report any of the following:

Headaches: ☐ Yes ☐ No
When? ________________
Blurred vision: ☐ Yes ☐ No
When? ________________
Double vision: ☐ Yes ☐ No
When? ________________
Eyes "hurt or tired": ☐ Yes ☐ No
When? ________________
List any other complaints your child makes concerning his/her vision: ________________
____
____
____
____

Have you ever noticed the following:

Eyes frequently reddened Yes No
If so, when?____________________

Frequent eye rubbing Yes No
If so, when?____________________

Frequent blinking Yes No
If so, when?____________________

Closing or covering one eye Yes No
If so, when?____________________

Head close to paper
when readingor writing: Yes No

Tilting head when reading: Yes No

Tilting head when writing: Yes No

Confuses letters or words: Yes No

Reverses letters or words: Yes No

Skips, rereads or omits words: Yes No

Vocalizes when reading silently: Yes No

Reads slowly: Yes No

Uses finger as a marker: Yes No

Poor reading comprehension: Yes No

Writes or prints poorly: Yes No

Tires easily: Yes No

Avoids near tasks: Yes No

Short attention span: Yes No

Poor motor coordination: Yes No

Difficulty catching/hitting a ball: Yes No

Television viewing: How much

How often ____________________

Viewing distance____________________

____

School

Age at time of entrance to kindergarten ________

First grade____________________

Does child like school? Yes No

Teacher? Yes No

School work is: ________ Above average

________ Average

________ Below average

Do you feel he/she is working up to potential? ____

____

Does teacher feel he/she is working up to potential?

What school subjects come easy for child? ______

____

Does child like to read? Yes No

Voluntarily? Yes No

What? ____________________

____

Specifically describe any school difficulties: ______

____

____

____

Has a grade been repeated? Yes No

Which? ____________________

Has he/she changed schools often?____________

____

When?____________________

Does he/she seem to be under tension or extreme
pressure when doing schoolwork?____________

____

Has he/she had any special tutoring and/or
remedial assistance? Yes No

When?____________________

From whom? ____________________

Where? ____________________

How long? ____________________

Results:____________________

How well developed is his/her spoken vocabulary?

____

What is the child's attitude toward reading, school,
his/her teacher, other youngsters?____________

____

____

General Behavior

Are there any behavior problems________________
School: ________________ Home: ________________
What causes these problems?
____
____
____

Child's reaction to fatigue:
Sad________________
Irritable ______________
Other________________

Child's reaction to tension?
Nail biting____________
Thumb sucking _______
Other________________

Does he/she say and/or do things impulsively? Yes No
In constant motion Yes No
Can't sit still for long periods? Yes No

Please indicate which adults he/she lives with:
____Mother ____Father
____Step Mother ____Step Father
____Foster parents ____Adopted parents
____Grandmother ____Grandfather
____Aunt ____Uncle
____Other

Has he/she ever been through a traumatic family situation? (Such as divorce, parental loss, separation) Yes No
What age was he/she?________________________
Does he/she seem to have adjusted?____________
Is family life stable at this time? Yes No

Family and Home

How does he/she get along with parents? ________
____
____
Siblings? ______________________________________
____
____
____
Classmates at school? __________________________
Playmates at home? ___________________________
Did father or anyone in father's family have a learning problem? Yes No
Who? ____
____
____
Did mother or anyone in mother's family have a learning problem? Yes No
Who? ____
____
____

Is there any history of cognitive impairment, psychological diagnosis, etc., on either side of the family? Yes No
Who? ____
Do any, or did any of the other children in the family have learning problems? Yes No
Who? ____
To what extent? ________________________________
____
____
____

Give a brief description of your child as a person:
____
____
____
____
____
____
____
____
____
____
____
____