

DEVELOPMENTAL HISTORY

Child's name _____ Birthday ____/____/____ Age _____

Grade _____ School's name and address _____

Teacher's name _____ Nurse's name _____

Mother's name _____ Occupation _____ Phone _____

Father's name _____ Occupation _____ Phone _____

Mailing address _____

Who referred you to this office? _____ Number children in family _____

I. Please state the major reason you would like your child examined: _____

II. Vision:	Yes	No	Unknown
1) Headaches	_____	_____	_____
2) Blurred distance vision	_____	_____	_____
3) Blurred reading vision	_____	_____	_____
4) Holds books closer than normal	_____	_____	_____
5) Eyes hurt	_____	_____	_____
6) Eyes tire	_____	_____	_____
7) Double vision	_____	_____	_____
8) Eye turn (crossed or wall-eyed)	_____	_____	_____
9) Blinks excessively	_____	_____	_____
10) Covers one eye while doing homework	_____	_____	_____

III. School:	Yes	No	Unknown
1) Is your child having problems in school?	_____	_____	_____
2) Does your child like the teacher?	_____	_____	_____
3) Is school satisfied with child's performance?	_____	_____	_____
4) Are you satisfied with child's performance?	_____	_____	_____
5) Do grades really show his or her ability?	_____	_____	_____
6) Is there trouble completing written assignments?	_____	_____	_____
7) Does your child lose his or her place while reading?	_____	_____	_____
8) Does your child misread words that are known?	_____	_____	_____

IV. **Behaviors:** Please rate the child on the following items: (Place a number in the blank to the left of the item which describes the child's school or home behavior.)

1. Always 2. Frequently 3. Occasionally 4. Rarely 5. Never 6. Unknown

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|----------------------------|-------------------------------------|
| _____ Hyperactive | _____ Poor ability to organize work |
| _____ Easily distracted | _____ Indistinct speech |
| _____ Short attention span | _____ Awkward or clumsy |
| _____ Easily frustrated | _____ Poor peer group relationships |
| _____ Impulsive | _____ Behavior problems |
| _____ Easily fatigued | _____ Emotional problems |

- _____ Confusion following a series of verbal instructions
- _____ Variable school performance (from hour to hour or day to day)
- _____ Reverse letters, words, or numbers in reading
- _____ Reverse letters, words, or numbers in writing
- _____ Shows confusion about right, left or other directional orientations

V. **Physical Development:** At what age in years and months did the child:
Speak words clearly _____ start to crawl _____ walk unaided _____
Which phrase describes the child's physical maturity (circle number)?

1. Physical immature for age 2. Average physical maturity for age 3. Advanced physical maturity for age

VI. **School Progress:** Rate your child's progress in the following subjects:

1. Below grade level 2. Grade level 3. Above grade level

____ Reading ____ Spelling ____ Writing ____ Arithmetic
____ Art ____ Physical Education ____ Others? _____

What specific type(s) of work is your child having trouble with? _____

Have other family members had difficulties learning any of the above subjects? Yes ____ No ____
If yes, state relationship to the child and subjects: _____

Does your child have memory difficulties? Yes ____ No ____ , if yes, what type of information? _____

VII. **General History:** Is there a history of pregnancy or birth complication? Yes ____ No ____
if yes, please explain: _____

Has there been any severe childhood illness, high fever, injury, or physical impairment? Yes ____ No ____
if yes, please explain: _____

Has the child received a hearing test? Yes ____ No ____ Date _____

Has a hearing or speech deficiency been previously diagnosed: Yes ____ No ____
if yes, please explain: _____

Has the child received a complete eye examination? Yes ____ No ____ Date _____

Has a visual problem been diagnosed? Yes ____ No ____
if yes, please explain: _____

Does the child have any allergies? Yes ____ No ____
if yes, please explain: _____

Is the child currently taking any medication or pills? Yes ____ No ____ If yes, please list the medications, their purposes, and duration: _____

Has the child previously taken medication for hyperactivity? Yes ____ No ____

VIII. **Therapy:** Has there been any previous therapy for learning difficulties or visual or speech problems?
Yes ____ No ____ , If yes, please state the type of therapy, duration and results: _____

If you wish a copy of our examination results sent to any individual or agency, please list the name and address below:

- 1) _____
2) _____
3) _____

Signature: _____ Date: _____
Relationship to child _____

