5012 Dorsey Hall Drive, Suite 105
Ellicott City, MD 21042

ELLICOTT CITY
TOTAL EYE CARE

ellicottcityeyes.com
410-730-8878

CHILD DEVELOPMENTAL QUESTIONNAIRE

Patient Name: ______________________ Date: __________

DOB: __________ Age: ______ Gender: ______

Address: ______________ City: __________ State: ______ Zip: ______

Father's Name: __________ Phone: __________ Email: ______________

Mother's Name: __________ Phone: __________ Email: ______________

Referred by: ______________

What do you expect to find out from the exam? ______________________

FAMILY

Father's Occupation: __________ Marital Status: __________ Grade Completed: ______

Mother's Occupation: __________ Marital Status: __________ Grade Completed: ______

Languages spoken in the home: ______________________

Siblings (age & gender): ______________________

DEVELOPMENTAL HISTORY

Is the child adopted? ☐ Yes ☐ No If yes, does the child know? ☐ Yes ☐ No Age when adopted? ______

Was pregnancy full-term? ☐ Yes ☐ No Child's weight at birth ______________

Any complications before, during or following deliver? ______________

In utero, was child exposed to: ☐ Drugs ☐ Alcohol ☐ Nicotine

At what age did the following occur?
Creeping (stomach on floor) ______ Crawling (stomach off floor) ______ Sitting on own______
Walking on own ______ Feeding self ______ Voluntary bladder control ______
Tendency to show handedness ______ Has anyone attempted to change handedness? ☐ Yes ☐ No

MEDICAL HISTORY

Has your child had any serious accidents, operations, or unusual illnesses? If so, please specify.

____
____
____
____

List any allergies: ______________________

List any medications/vitamins currently taken: ______________________

Last Medical Exam: __________ Pediatrician: ______________

Recommendations by Pediatrician: ______________________

Does test taking appear to cause anxiety? ☐ Yes ☐ No

Has your child or family been referred for counseling? ☐ Yes ☐ No Was it successful? ☐ Yes ☐ No

Reason for referral: ______________________

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VISION CARE

Last Eye Exam: ____________ Practice/Doctor: ____________

Does your child wear glasses? ☐ Yes ☐ No If yes, how old are the glasses? ____________

Has your child been treated with a patch or eyedrops for Amblyopia? ☐ Yes ☐ No

If yes, describe the treatment plan: ____________

GENERAL DEVELOPMENT SKILLS

At what age did the following occur? Speak first sentence ______ Ask first questions ______

Was there another communication method before speech? ____________

Does your child have a speech/language deficit? ____________

Has your child had speech therapy? ☐ Yes ☐ No If yes, was it successful? ☐ Yes ☐ No

Has your child had physical therapy? ☐ Yes ☐ No If yes, was it successful? ☐ Yes ☐ No

Has your child had occupational therapy? ☐ Yes ☐ No If yes, was it successful? ☐ Yes ☐ No

GENERAL HEALTH

Does your child sleep through the night? ☐ Yes ☐ No Average hours of sleep per night: ______

Does your child have a good diet? ☐ Yes ☐ No

Does you child eat fruits & vegetables? ☐ Yes ☐ No

Does your child take vitamins? ☐ Yes ☐ No

Is there a high desire for junk food? ☐ Yes ☐ No

Does your child have food allergies? ☐ Yes ☐ No If yes, explain: ____________

Is your child on a restricted diet? ☐ Yes ☐ No If yes, explain: ____________

FAMILY AND HOME

What responsibilities does your child have at home? ____________

Does your child carry these responsibilities out independently? ☐ Yes ☐ No

Child’s interests and hobbies: ____________

Any tensional behavior such as nail biting, excessive eye blinking/rubbing, tantrums, or tongue chewing?
____

What discipline is most effective in guiding your child? ____________

What adults besides parents play an active part in guiding your child? ____________

GENERAL MOVEMENT

Is your child physically active? ☐ Yes ☐ No

Does your child avoid sports? ☐ Yes ☐ No

Team Sports: ____________

Individual Sports: ____________

Can your child catch a ball? ☐ Yes ☐ No

Can your child throw a ball? ☐ Yes ☐ No

Does your child have good rhythm? ☐ Yes ☐ No

I would consider my child ☐ Clumsy ☐ Coordinated

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SCHOOL INFORMATION

List the schools your child has attended, beginning with their current school (including home school).

Name	Location	Grade Level

Does your child like school? ☐ Yes ☐ No Is their attendance regular? ☐ Yes ☐ No

Has your child ever been held back? ☐ Yes ☐ No What grade? ________ Child's Reaction: ________________

What is the school structure (traditional, open classroom, etc)? ________________

What is your child's favorite subject? ________________

How does your child perform 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 in 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

How does your child answer homework problems? ☐ Memorize answers ☐ Think it through

What is child's attitude towards present teachers? ________________

What is child's attitude towards teachers in general? ________________

What type of teacher is your child most responsive to (male, female, strict, flexible, etc)?

____

How would you rate your child's popularity among their classmates (popular, accepted, ignored, etc)?

____

Does the school consider your child to have a

Learning problem? ☐ Yes ☐ No Explain: ________________

Discipline problem? ☐ Yes ☐ No Explain: ________________

Has your child had any testing does at the school level? ☐ Yes ☐ No Explain: ________________

Does your child like to read? ☐ Yes ☐ No If yes, what materials? ________________

I have read and answered all pages to the best of my ability.

Signature: ________________ Print Name: ________________

Relationship to Child: ________________ Date: ________________

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QUALITY OF LIFE CHECKLIST

Patient Name: ______________________ Completed by: ______________ Date: ________

Check the column which best represents the occurrence of each symptom	**Never 0**	**Seldom 1**	**Occasionally 2**	**Frequently 3**	**Always 4**
Blurred close vision					
Double vision					
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Fall asleep reading					
See worse at end of the day					
Skip/repeat lines while reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from board					
Avoid near work/reading					
Omit small words when reading					
Write uphill/downhill					
Misalign digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble staying focused on reading					
Difficulty completing work on time					
Says, “I can’t” before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Difficulty judging distance					
Clumsy, knock over things					
Poor time use/management					
Does not make change well					
Lose things/belongings					
Car or motion sickness					
Forgetful/poor memory					
Total for each column	____x0=0	____x1=____	____x2=____	____x3=____	____x4=____
Grand Total *(sum of each column)*					