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:__			
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

_____Hyperactive
_____Easily distracted
_____Short attention span
_____Easily frustrated
_____Impulsive
_____Easily fatigued

_____Poor ability to organize work
_____Indistinct speech
_____Awkward or clumsy
_____Poor peer group relationships
_____Behavior problems
_____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_____