DEVELOPMENTAL HISTORY

Child's Name: _____ Birthday: ____/____/_____ Age: ___yr ___ mo Grade: ____
Parent/ Guardian(s) Name: _____ Occupation: _____ Phone: _____
Parent/ Guardian(s) Name: _____ Occupation: _____ Phone: _____
Who referred you to this clinic/ Relationship to patient? _____ # of children in family: ___

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

_____

II. Vision (Please place a check in the appropriate box)

Question	**Never (0)**	**Rarely (1)**	**Occasionally (2)**	**Frequently (3)**	**Always (4)**
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to re-read the same line of words when reading?					
Do you ever experience blurred distance vision?					
Do you ever hold reading material closer than normal?					
Do you have double vision at distance?					
Do you have an eye turn? (Crossed or wall-eyed)					
Do you blink excessively?					
Do you cover one eye while doing homework?					

III. Behavior (Please place a check in the appropriate box)

Behavior	**Never**	**Rarely**	**Occasionally**	**Frequently**	**Always**
Hyperactive					
Easily distracted					
Short attention span					
Easily frustrated					
Impulsive					
Easily fatigued					
Poor ability to organize work					
Indistinct speech					
Awkward or clumsy					
Behavior problems					
Emotional problems					
Confusion following a series of verbal instructions					
Variable school performance (from hour to hour/ day to day)					
Reverses letters, words, or numbers in reading					
Reverses letters, words, or numbers in writing					
Shows confusion about right or left					
Shows confusion about directional orientation					

Please turn →

IV. School Information:

School Name: _____ Address: _____

Resources/Accommodations	No	Yes	If yes, since when and for what areas?
504 Plan in place?			
IEP (Individualized Education Program) in place?			

Progress: Rate your child's progress in following subjects. **(Please place a check in the appropriate box & any comments.)**

Subject	Above grade level	At grade level	Below grade level	What specific areas or academic skills is your child experiencing difficulty? Comments:	Any family member with learning difficulties? Please indicate subject and relationship to child.
Reading					
Spelling					
Writing					
Arithmetic					
Art					
Music					
Phys. Education					
Other? Please list:					

V. General Health and Developmental History:

	No	Yes	If yes, please explain:
Any severe childhood illness, high fever, injury, or physical impairment?			
Any diagnosed hearing impairment?			Date of last hearing test:
Any diagnosed speech/ language deficiency?			Date of speech/ language evaluation:
Any diagnosed visual problems?			Date of last eye exam:
Any allergies?			
Any medications and/ or vitamins?			Please list, including purpose, dosage, duration of treatment:
History of previous (or current) therapy for learning, visual, occupational, physical, and/ or speech difficulties?			Please list, including type of therapy, duration, and results:

VI. Pregnancy & Birth History:

	Yes	No	Comments
Normal pregnancy?			
Normal birth history?			
Normal gestation time			If premature, number of weeks? =
Normal birth weight			Lbs: _____, Oz:_____ Current weight: Lbs: _____ Height: _____ft _____ in
Normal Apgar score			Score: _____

VII. Developmental Milestones:

	Yes	No	If no, when?
Turned head to locate sound by 6 months			
Followed simple instructions by age 2 yrs			
Said first word at 12 months			
Used sentences of more than three words by age 4 yrs			
Reached for objects by 7 months			
Searched for objects that are hidden while watching by 12 months (Ex: Peek-a-boo)			
Copied a circle by age 4 yrs			
Grasped a crayon between thumb & finger by age 4			
Walked unaided by 18 months			
Jumped in place by age 4 yrs			

Signature: _____ Date: _____

Relationship to child: _____ Parent/Guardian email address: _____

Thank you! ☺