

## 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

_____ 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 \_\_\_\_\_

