

## DEVELOPMENTAL HISTORY

Child's Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_yr \_\_\_\_ mo  
 Grade \_\_\_\_\_ School's Name and Address: \_\_\_\_\_  
 Teacher's Name \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Who referred you to this clinic? \_\_\_\_\_ Number of children in family \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**II. Vision:**

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

Yes	No	Comments

**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 your child on the following items: (Place a number in the blank space to the left of the item, which best describes his/her school or home behavior).

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

____ Hyperactive	____ Poor ability to organize work	____ Confusion following a series of verbal instructions
____ Easily distracted	____ Indistinct speech	____ Variable school performance from hour to hour/day to day
____ Short attention span	____ Awkward or clumsy	____ Reverses letters, words or numbers in reading
____ Easily frustrated	____ Poor peer group relationships	____ Reverses letters, words or numbers in writing
____ Impulsive	____ Behavior problems	____ Shows confusion about right or left
____ Easily fatigued	____ Emotional problems	____ Shows confusion about directional orientation

**V. Physical Development:** At what age in years and months did your child:

Speak words clearly \_\_\_\_\_ start to crawl \_\_\_\_\_ walk unaided \_\_\_\_\_  
 - over -

**Which phrase describes the child's physical maturity ( please 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  
\_\_\_ Art

\_\_\_ Spelling  
\_\_\_ Physical Education

\_\_\_ Writing  
\_\_\_ Other? \_\_\_\_\_

\_\_\_ Arithmetic

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

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

Does your child have memory difficulties? No \_\_\_ Yes \_\_\_ If so, what type of information?  
\_\_\_\_\_

**VII. General History:** Is there a history of pregnancy or birth complications? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Has there been any severe childhood illness, high fever, injury or physical impairment? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Has your child received a hearing test? No \_\_\_ Yes \_\_\_ Date \_\_\_\_\_  
Has a hearing or speech deficiency been previously diagnosed? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Has your child received a complete eye examination? No \_\_\_ Yes \_\_\_ Date \_\_\_\_\_  
Has a visual problem been diagnosed? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Does your child have any allergies? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Is your child currently taking any medications or pills? No \_\_\_ Yes \_\_\_  
If yes, please list the medications, their purposes, and duration: \_\_\_\_\_  
\_\_\_\_\_

Has your child previously taken medication for hyperactivity? No \_\_\_ Yes \_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_  
Comments: