Extended Developmental History Form – School Age

Name: _____ M / F Date: _____

Age: _____ yrs. _____ mos. Date of Birth: _____ Grade: _____

Name and address of school: _____

Teacher's name: _____ School Nurse: _____ Principal:_____

EDUCATIONAL HISTORY

Does your child like school? Y / N School work is: _____ above average _____ average _____ below average

Has your child repeated any grades? Y / N Explain: _____

Is (or has) your child receiving any tutoring, extra help, or special classes in school? Y / N Explain: _____

Has there been any evaluations done at school or by school recommendation (psychological, learning, speech/language, neurological, occupational/physical therapy, medical)? Y / N If yes, list tests briefly and describe results: _____

_____

_____

What subjects are easy for your child? _____

What subjects are hard for your child? _____

Please check if your child has difficulties in any of the following areas:

_____ reading	_____ handwriting	_____ math
_____ spelling	_____ copying from the board	_____ attention span
_____ behavior / attitude	_____ motivation	_____ organization

Does your child like to read? Y / N Explain: _____

Do you feel your child is a good reader? Y / N Explain: _____

Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

_____ comprehension	_____ word recognition	_____ phonics
_____ slow reading	_____ omits small words	_____ reverses letters or words
_____ avoidance	_____ eye strain	_____ easily distracted
_____ comprehension declines the longer he/she reads	_____ fatigue	_____ vocalizes when reading

Do you feel that your child is performing up to their potential in school? Y / N Explain: _____

_____

_____

Please check any of the following that you have noticed or that your child complains about:

_____ blurred vision	_____ double vision	_____ eye turns in, out, up, down
_____ closes or covers an eye	_____ headaches	_____ eyes "hurts" or are "tired"
_____ words move around on page	_____ motion sickness	_____ squints or blinks excessively
_____ eye strain	_____ holds book or paper too close	_____ loses place when reading
_____ uses finger to read	_____ skips or rereads words/lines	_____ frequent reversals

VISUAL HISTORY – *Please complete this section if you were referred in from another eye doctor's office or are new to our office.*

Eye doctor's name: _____ Date of last visit: _____ Reason for visit: _____

Results of exam: _____ Glasses prescribed? Y / N

Is glasses were prescribed, when are they to be worn? _____ Are they worn? Y / N

DEVELOPMENTAL HISTORY

Were there any complications with pregnancy or during birth? Y / N Explain: _____

_____

_____

Was your child born prematurely? Y / N If yes, how early? _____ Did your child receive oxygen at birth? Y / N # of days ___

Child's birth weight _____ APGAR score _____ Other circumstances: _____

Did your child crawl (stomach on floor)? Y / N _____ early _____ on time _____ delayed or late

Did your child creep (stomach off floor)? Y / N _____ early _____ on time _____ delayed or late

When did your child begin walking unassisted? _____ early _____ on time _____ delayed or late

When did your child first begin to say words? _____ early _____ on time _____ delayed or late

When did your child begin to say 2 to 3 word phrases? _____ early _____ on time _____ delayed or late

Any speech problems now or in the past? Y / N If yes, explain: _____

Any problems with fine motor coordination? Y / N If yes, explain: _____

Is your child clumsy? Y / N If yes, explain: _____

Any problems with activities requiring good balance? Y / N If yes, explain: _____

How would you describe your child? _____ active_____ moderately active _____ extremely active

Does your child say or do things impulsively? Y / N

Can your child sit still for long periods of time? Y / N

FAMILY AND HOME

Please indicate which adult(s) the child lives with: _____ mother _____ father _____ stepmother _____ stepfather _____ other

Please list others in the child's household (include name, age, and relation): _____

_____

Does child spend time with any other person not in the home? Y / N If yes, explain: _____

Has your child ever been through a traumatic family situation (divorce, parental loss, separation, severe parental illness, etc)? Y N

If yes, explain: _____

Does you child seem to have adjusted? Y / N

Is family life stable at this time? Y / N If no, explain: _____

Is there a history of a learning problem in the family? Y / N If yes, explain:_____

_____

_____

Give a brief description of your child as a person: _____

_____

_____

_____

Is there any other information that you feel would be helpful or import in our care of your child? _____

_____

_____

_____