Vision Learning Center™ - Child's Developmental History Form

Child's Name _____ Birth Date ___ / ___ / ___ Age:_____
Nickname _____School _____Grade _____
Sibling's Names & Ages _____

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed (if any)? _____

DEVELOPMENTAL & BEHAVIORAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ If no, how many weeks early? _____ Birth weight _____
Normal birth? Yes ☐ No ☐ If no, please list any complications before, during or immediately following delivery _____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ Approx. age? _____
Creep (on all fours?) Yes ☐ No ☐ Approx age?_____ Walked at Approx age?_____
At what age did your child first speak?_____Is speech clear now? Yes ☐ No ☐
Did your child have chronic ear infections? Yes ☐ No ☐ If yes, were tubes given? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development? Yes ☐ No ☐
If yes, why? _____
Hand preference was clearly indicated at what age? _____ R L or Both (Please circle)
Has your child received any special developmental guidance/ assistance? Yes ☐ No ☐
If yes, explain: _____
Has there been any indications of hearing problems? Yes ☐ No ☐
Has there been any injuries to the head, eyes, ears or neck? Yes ☐ No ☐ When?_____
Describe Injury:_____
Was an MRI or CAT scan given? Yes ☐ No ☐ If yes, what were results?_____

Has a neurological, psychological, occupational therapy, physical therapy, speech, or hearing evaluation been performed in the past? If therapy services were given, please give date range.

TYPE OF EVALUATION	WHEN	BY WHOM	DIAGNOSIS / RESULTS	THERAPY RECEIVED

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervous	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Bad temper	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain): _____

FAMILY AND HOME

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐ If yes, at what age? _____
Was counseling / therapy undertaken? Yes ☐ No ☐ If yes, is it still on-going? Yes ☐ No ☐
Does your child seem to have adjusted? Yes ☐ No ☐ Is family life stable at this time? Yes ☐ No ☐

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON AND SHARE ANY OTHER INFORMATION YOU FEEL WOULD BE IMPORTANT IN THE TREATMENT OF YOUR CHILD: _____

Section A – School Age

ACADEMIC HISTORY - If your child is in school, please fill out this section, otherwise skip to Section B:

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Specifically describe any school difficulties: _____

_____

Has your child changed schools often? Yes ☐ No ☐ If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐ If yes, which and why? _____
Is your child currently being evaluated for special education services? Yes ☐ No ☐ If so, when is your ARD Meeting scheduled? _____ Is your child already on a 504 Plan or IEP? Yes ☐ No ☐
If yes, circle which one and list the qualifying label used? _____
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____How long? _____
Results: _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Does your child like to read? Yes ☐ No ☐ Voluntarily? Yes ☐ No ☐
Does your child like school? Yes ☐ No ☐

WHICH CLASS SUBJECTS ARE:

Above average: _____

Average: _____

Below average: _____

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐
Child's favorite subjects? _____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☐ No ☐ If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐ If yes, what? _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐ Can your child sit still for long periods? Yes ☐ No ☐

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much & often? _____
Does your child spend time using computers? Yes ☐ No ☐ If yes, how much & often? _____
Does your child spend time using video games? Yes ☐ No ☐ If yes, how much & often? _____
Are there any activities your child would like to participate in, but doesn't? Yes ☐ No ☐
Please explain _____
Is your child seriously involved with athletics? Yes ☐ No ☐
Which sports does he/she play seriously (list all)?_____

_____

Do you feel they are achieving up to your potential in these sports? Yes ☐ No ☐ If not, please describe _____
What other activities occupy your child's leisure time? _____

_____

Section B – Infant/Toddler/Developmentally Delayed

PRE-SCHOOL/DAYCARE - If your child attends preschool or daycare, please fill out the following:

Name of Pre-school/Daycare: _____

Does your child like pre-school/daycare? Yes ☐ No ☐ Does your child like the teacher? Yes ☐ No ☐

Compared to other children his/her age, does general performance and social skills seem to be:

above ☐ equal to ☐ or below ☐ ? Please explain: _____

Which pre-school activities are easy for your child? _____

Specifically describe any pre-school / day care concerns / difficulties: _____

_____

PRESENT SITUATION

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	_____
Reddened or encrusted eyelids	☐	☐	_____
Frequent sties	☐	☐	_____
Eyes in constant motion	☐	☐	_____
Eyelids droop	☐	☐	_____
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	_____
Is abnormally bothered by bright light	☐	☐	_____
Has watery eyes	☐	☐	_____
Turns or Tilts head to one side	☐	☐	_____
Moves objects very close to look at them	☐	☐	_____
Squints or Blinks excessively while looking at objects	☐	☐	_____
Has a tendency to rub eyes	☐	☐	_____
Covers or closes one eye	☐	☐	_____
Stumbles over objects or is clumsy	☐	☐	_____
Poor motor control	☐	☐	_____
Lacks interest in looking at objects or seeing	☐	☐	_____
Unable to see distant objects	☐	☐	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	_____
Is unable to stack blocks or other objects	☐	☐	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐

If yes, explain: _____

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes ☐ No ☐ Can your child identify numbers or letters? Yes ☐ No ☐

Does your child like to draw/color? Yes ☐ No ☐ Is your child learning to read? Yes ☐ No ☐

How is your child performing as compared to others his/her age: Above average ☐ Below average ☐