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# SCHOOL AGE CHILD HISTORY

***Please fill out this form carefully and bring it with you to your appointment.***

## A. GENERAL INFORMATION

Child's full name ______________________________ Present age ______ Birth date ______________

Name and address of school ______________________________________________

______________________________________________

Grade _________ Teacher ___________________ School Nurse _____________________ Principal _________________

Is your child especially afraid of doctors? O Yes O No Child's handedness: O Right O Left

Referred by: ______________________________________________

## B. FAMILY

Father ______________________________ Birth date ____________________

Mother ______________________________ Birth date ____________________

Brothers ______________________________ Birth date ____________________

& ______________________________ Birth date ____________________

Sisters ______________________________ Birth date ____________________

## C. PARENT INFORMATION

Home address ______________________________ City __________________ State ____ Zip __________

Occupation ______________________________ Home Phone ____________________

Email ______________________________ Fax Number ____________________

Mother Employer ______________________________ Business Phone ____________________

Business address ______________________________ City __________________ State ____ Zip __________

Father Employer______________________________ Business Phone ____________________

Business address ______________________________ City __________________ State ____ Zip __________

Do you have Major Medical Insurance? O Yes O No

If so, what is the carrier? ______________________ Policy # ______________________

## D. MEDICAL HISTORY

Child's most recent medical examination: ______________________________________________

Doctor's name Date

______________________________________________

Results

Medications currently using: For what condition:

______________________________________________

______________________________________________

Any history of the following in your family? O Diabetes O Glaucoma O High Blood Pressure

Has your child been diagnosed as having any of the following?

O Learning Disabilities O Developmental delays O ADD or ADHD O Cerebral Palsy

O Seizure disorders O Autism O Other ______________________________

List illnesses, bad falls, head injuries, high fevers, etc.

______________________________________________

______________________________________________

Is your child generally healthy? O Yes O No
Are there any chronic problems like asthma, hay fever, allergies? O Yes O No If so, please list: ___________________
______________________________________________________________________________________________

Has a Neurological Evaluation been performed? O Yes O No By whom? ______________________________________
Results? ___________________________________________________________________________________
Has a Psychological Evaluation been performed? OYes O No By whom? ______________________________________
Results? ___________________________________________________________________________________
Does your child currently receive:
O Occupational therapy services? By Whom? _____________________________________________________
Results? ______________________________________________________________________________
O Physical therapy services? By Whom? __________________________________________________________
Results? ______________________________________________________________________________
O Speech therapy services? By Whom? ___________________________________________________________
Results? ______________________________________________________________________________
O Other therapy services? By Whom? ____________________________________________________________
Results? ______________________________________________________________________________

## E. *NUTRITIONAL INFORMATION*

Current diet: O Excellent O Good O Fair O Poor
Does your child like or crave sweets? O Yes O No
Is your child active? O Not active O Moderately active O Extremely active
Are there periods of very high energy? O Yes O No low energy? O Yes O No

## F. *DEVELPOMENTAL HISTORY*

Full term pregnancy? O Yes O No Normal birth? O Yes O No
Any complications before, during, or immediately following delivery? _____________________________________________

Did your child crawl (stomach on floor)? O Yes O No Age? _____________
creep (stomach off floor)? O Yes O No Age? _____________
move on all fours? O Yes O No If not, please describe ___________________________________________
At what age did your child walk? _____________ Was child active? μ Yes μ No
Speech: First words at age _______________ Was speech clear to others? ___________________________________
Is it clear now? O Yes O No Explain: _____________________________________________________________

Any history of crossing eyes? O Yes O No What age first noticed? _________________________________________
Any *family* history of crossing eyes? O Yes O No Who? ___________________________________________________

## G. *VISUAL HISTORY*

Child's most recent vision examination: ____________________________________________________________
Doctor's name Date
____________________________________________________________
Results
Reason for examination: _____________________________________________________________________________
Were glasses prescribed? O Yes O No Are they worn? O Yes O No When? ___________________________

Members of the family who have had visual attention and why:

| Name | Age | Visual Situation |
| --- | --- | --- |
| | | |
| | | |
| | | |

## H. *PRESENT SITUATION*

Is there any evidence from the school or psychological tests that some visual malfunction may be present? O Yes O No

If so, what ______________________________

List any other complaints your child makes concerning his/her vision. ______________________________

______________________________

| Have you ever noticed the following? | Yes | No | If so, when? |
|---|---|---|---|
| *Appearance of Eyes* | | | |
| Eye frequently reddened | O | O | ______________ |
| Frequent eye rubbing | O | O | ______________ |
| Frequent blinking | O | O | ______________ |
| *Refractive Error of Focusing Problem* | | | |
| Blinks excessively during near tasks | O | O | ______________ |
| Avoids close work | O | O | ______________ |
| Fatigues easily during visual tasks | O | O | ______________ |
| Complains of blur while reading or writing | O | O | ______________ |
| Poor reading comprehension | O | O | ______________ |
| *Eye Tracking (Ocular Motility) Problem* | | | |
| Skips, rereads, or omits words | O | O | ______________ |
| Vocalizes when reading silently | O | O | ______________ |
| Reads slowly | O | O | ______________ |
| Uses finger as marker | O | O | ______________ |
| Repeatedly omits small words | O | O | ______________ |
| Moves head excessively while reading | O | O | ______________ |
| Mistakes words with similar beginnings or endings | O | O | ______________ |
| *Eye Teaming (Binocularity) Problems* | | | |
| Complains of seeing double | O | O | ______________ |
| Covers or closes one eye | O | O | ______________ |
| One eye turns (in, out, up or down) | O | O | ______________ |
| Tilts or turns head to one side | O | O | ______________ |
| Complains of letters or lines “moving” | O | O | ______________ |
| *Visual Information Processing Problem* | | | |
| Fails to recognize same word in next sentence or page | O | O | ______________ |
| Difficulty following verbal instructions | O | O | ______________ |
| Poor printing or handwriting | O | O | ______________ |
| Confuses letters or words | O | O | ______________ |
| Reverses letters or words | O | O | ______________ |
| Poor reading comprehension | O | O | ______________ |
| Writes or prints poorly | O | O | ______________ |
| Poor eye hand coordination | O | O | ______________ |
| Repeatedly confuses right-left directions | O | O | ______________ |
| Poor recall of visually-presented tasks | O | O | ______________ |
| Poor motor coordination | O | O | ______________ |
| Difficulty hitting/catching ball | O | O | ______________ |
| School performance not up to potential | O | O | ______________ |

Television viewing How much ______________ How often ______________ Viewing Distance __________

## I. SCHOOL

Age at time of entrance to: Kindergarten ______________ First grade ______________

Does child like school? O Yes O No Teacher? O Yes O No

School work is: O Above Average O Average O Below Average

***Do you feel that (s)he is working up to potential? O Yes O No***

Does the teacher feel that (s)he is working up to potential? O Yes O No

What school subjects come easy for child? ______________________________

Does child like to read? O Yes O No Voluntarily? O Yes O No What? ______________________________

Specifically describe any school difficulties: ______________________________

______________________________

______________________________

______________________________

Has a grade been repeated? O Yes O No Which? ______________________________

Has (s)he changed schools often? O Yes O No When? ______________________________

Does (s)he seem to be under tension or extreme pressure when doing school work? O Yes O No

Explain: ______________________________

Has (s)he had any special tutoring and/or remedial assistance? O Yes O No How long? ______________

When? ______________________________ From Whom? ______________________________

Results? ______________________________

What is the child's attitude toward reading, school, his/her teachers, other youngsters? ______________________________

______________________________

How well developed is his/her spoken vocabulary? ______________________________

## J. GENERAL BEHAVIOR

Are there any behavior problems? School O Yes O No Home O Yes O No

What causes these problems? ______________________________

______________________________

Child's reaction to fatigue? O Sag O Irritable O Other ______________________________

Child's reaction to tension? O Nail biting O Thumb sucking O Other ______________________________

Does (s)he say and/or do things impulsively? O Yes O No In constant motion? O Yes O No

Can the child stay still for long periods of time? O Yes O No

## K. FAMILY AND HOME

Please indicate which adults the child lives with: O Mother O Father O Step Mother O Step Father O Aunt O Uncle O Grandmother O Grandfather O Adoptive Parents O Foster Parents O Other

Has (s)he been through a traumatic family situation? (Such as divorce, parental loss, separation, severe parental illness) O Yes O No

What age was the child when this situation occurred? ___________ Has the child adjusted? O Yes O No

Is family life stable at this time? O Yes O No

How does (s)he get along with:

Parents? ______________________________

Siblings? ______________________________

Classmates in school? ______________________________

Playmates at home? ______________________________

Did father or anyone in father's family have a learning problem? O Yes O No If so, who? ______________________

If so, who? __________________ Explain ______________________________

Did mother or anyone in mother's family have a learning problem? O Yes O No If so, who? ______________________

If so, who? __________________ Explain ______________________________

Is there any history of mental retardation, psychological disturbance, etc. on either side of the family? O Yes O No

If so, who? __________________ Explain ______________________________

Any of the other children in the family have a history of learning problems? O Yes O No
If so, who? __________________ Explain ______________________________________________________________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

__________________________________________________________________________________________

## *L. REPORT POLICIES*

Would you like copies of any reports? O Yes O No Would you like copies of any reports sent to anyone else? If so, please list name and address. ______________________________________________________________________

Please sign below to give us permission to release information about your child to the above sources. (Valid for 90 days only)

Signed ___________________________________________________________ Date ____________________