



## **Student History Form**

### **GENERAL INFORMATION**

Child's Full Name \_\_\_\_\_ Goes by: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone # \_\_\_\_\_ Child's Age: \_\_\_\_\_  
DOB \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Father's Name: \_\_\_\_\_  
Guardians: \_\_\_\_\_  
Child Resides With: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Email: \_\_\_\_\_

School Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Teachers Name: \_\_\_\_\_  
Child's grade in school: \_\_\_\_\_

How did you hear about our center? \_\_\_\_\_  
Who is your medical insurance carrier? \_\_\_\_\_

### **PRESENT SITUATION**

Why do you wish to have your child evaluated? \_\_\_\_\_

List any complaints your child makes concerning his/her vision: \_\_\_\_\_

At what age did the problem begin and under what circumstances: \_\_\_\_\_

Has the problem become better or worse? \_\_\_\_\_ Explain: \_\_\_\_\_

Does anyone else in the family have a similar problem? \_\_\_\_\_

Has there been any previous treatment? \_\_\_\_\_

Does the child feel that he/she has a problem? \_\_\_\_\_

If yes, what is the child's attitude toward the problem? \_\_\_\_\_

## **MEDICAL HISTORY**

List any illnesses, seizures, accidents, surgeries, fevers, etc. That the child has experienced:

<b>Illness/Injury</b>	<b>Age</b>	<b>Type of Severity</b>	<b>Complications (if any)</b>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any prescription or over-the-counter medication(s) being taken, dosage, name reason: \_\_\_\_\_

\_\_\_\_\_

Health at present: **Excellent** **Good** **Fair** **Poor**

Does the child suffer from any chronic problems such as asthma, colds, allergies or ear infections? \_\_\_\_\_

When was your child's last eye exam? \_\_\_\_\_

Clinic name and address: \_\_\_\_\_

Were glasses recommended or prescribed at their last vision examination? Yes No

Were treatment recommendations made? Yes No, If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Was the treatment program followed? Yes No

Was the treatment effective? Yes No

Has a vision therapy program ever been recommended? Yes No

o If yes has the program been completed? Yes No

Members of the family who have had vision treatment and why?

<b>Name</b>	<b>Age</b>	<b>Visual Condition/Treatment</b>
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any indications of hearing or speech-related problems? Yes No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

## DEVELOPMENTAL HISTORY

List any medications taken or complications during pregnancy:

\_\_\_\_\_

\_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Natural or C-Section: \_\_\_\_\_

Complications before, during or following delivery: \_\_\_\_\_

\_\_\_\_\_

Did you child crawl (stomach on floor)? Yes No At what age? \_\_\_\_\_

On hand and knees? Yes No At what age? \_\_\_\_\_

Was there anything unusual about crawling or early motor development? \_\_\_\_\_

At what age did your child walk? \_\_\_\_\_

Did arm or legs require braces? Yes No

Which hand does your child use for Eating? \_\_\_\_\_ Writing? \_\_\_\_\_

Throwing? \_\_\_\_\_

Has he/she always used the same hand? Yes No

Was any guidance given? Yes No

Which foot doe he/she use for kicking? \_\_\_\_\_ Hopping? \_\_\_\_\_

Your child's first words were at age: \_\_\_\_\_

Was early speech clear to others? Yes No

Is it clear now? Yes No

## **GENERAL BEHAVIOR**

Does he/she actively participate in play, sports, or athletics? Yes No

Which ones? \_\_\_\_\_

Does he/she enjoy music? Yes No

Can he/she carry a tune? Yes No

Can he/she keep rhythm? Yes No

Are there any behavior problems? Yes No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

What causes these problems? \_\_\_\_\_

\_\_\_\_\_

## EDUCATIONAL HISTORY

Age at time of entrance to: Kindergarten: \_\_\_\_\_

First grade: \_\_\_\_\_

Does your child like school? \_\_\_\_\_

Does your child like the teacher? \_\_\_\_\_

School work is: Above average  
Average  
Below average  
Well below average

Do you feel that he/she is working up to his/her potential? \_\_\_\_\_

Specifically describe any school difficulties: \_\_\_\_\_

\_\_\_\_\_

What subjects are easy for your child? \_\_\_\_\_

Possible reasons for difficulties? \_\_\_\_\_

Has a grade been repeated? \_\_\_\_\_ If yes which grade? \_\_\_\_\_

Does your child attend any special need classes? Yes No

If yes, explain: \_\_\_\_\_

Has attendance been regular? Yes No If no, explain: \_\_\_\_\_

Does your child like to read? Yes No Voluntarily? Yes No

If yes, what? \_\_\_\_\_

Does your child prefer to be read to rather than reading on his/her own? Yes No

Has your child ever been classified as ADD, ADHD, LD, dyslexic, or any other diagnosis? Yes No

Please list any psychological or educational tests performed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## HOME ENVIRONMENT

Who lives in the home? Please give ages, gender, and relationship to the child:

Name	Age	Gender	Relationship to the child
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional home information we should know (frequent moving, separation, divorce, remarriage, death, etc.) \_\_\_\_\_

\_\_\_\_\_

Previous nursery or other group experiences (Sunday school, camp, daycare, etc.):

\_\_\_\_\_

\_\_\_\_\_

## INTERESTS AND HOBBIES

Does he/she have any special abilities (art, music, etc.)? \_\_\_\_\_

\_\_\_\_\_

Favorite activities-what does your child find most rewarding? \_\_\_\_\_

Give a brief description of your child's personality: \_\_\_\_\_

\_\_\_\_\_