



Pre-Kindergarten History Form

GENERAL INFORMATION

Child's Full Name: _____ Goes by: _____

DOB _____ Child's Age: _____

Mother's Name: _____

Father's Name: _____

Guardians: _____

Primary Residence – Resides with: _____

Street Address: _____

City _____ State: _____ Zip: _____

Home phone # _____

Check if child does not have a secondary residence

Secondary Residence – Resides with: _____

Street Address: _____

City _____ State: _____ Zip: _____

Home phone # _____

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? _____

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? _____

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

Name	Age	Visual Condition/Treatment
_____	_____	_____
_____	_____	_____

Has your child ever been diagnosed with ADD, ADHD, LD, Dyslexia, Autism/Autism Spectrum Disorder or any other diagnosis? Yes No

Please list any psychological or educational tests performed: _____

MEDICAL HISTORY

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

Illness/Injury	Age	Severity	Complications (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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? _____

Are there any indications of hearing or speech-related problems? Yes No
If yes, explain: _____

Last Medical Exam was on ____/____/____ Doctor: _____

Current Medications (dose and reason for taking): _____

Immunizations up to date? Yes No

Any Reactions to Immunizations: _____

VISUAL HISTORY

Has your child had a comprehensive eye exam with an Optometrist or Ophthalmologist? Yes No

If yes, when was your child's last eye exam? _____

Clinic name and address: _____

Were glasses recommended at any of their previous vision examination(s)? Yes No

Are they used? Yes No If yes, when? _____

If not used, why not? _____

Were treatment recommendations made at any time for your child? 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?

Name	Age	Visual Condition/Treatment
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_____	_____	_____
_____	_____	_____

Does your child verbalize any problems/complaints about his/her vision Yes No

If yes, explain: _____

DEVELOPMENTAL HISTORY

List any medications taken or complications during pregnancy:

Length of pregnancy: _____ Natural or C-Section: _____

Were fertility treatments used (such as IVF)? _____

Complications before, during or following delivery: _____

Were forceps or suction used? _____

Induction/Pitocin used? _____

What percent of the waking hours is/was your child in a play pen? _____

In a walker? _____ In a seat? _____

Did your child have a coordinated crawl and creep before he/she walked? Yes No
Did your 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

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 does he/she use for kicking? _____ Hopping? _____

What were your child's first words? _____ At what age? _____
Was early speech clear to others? Yes No
Is it clear now? Yes No
How well developed is your child's spoken vocabulary? _____

How well does your child understand/respond to spoken language? _____

How is your child performing as compared to others his/her age?
Average Above Average Below Average

Was there ever any reason for concern over your child's general growth or development? _____
Has your child received any special developmental guidance/assistance? Yes No
If yes, explain: _____

What things can your child do very well? _____

What things, if any, are difficult for your child? _____

Can your child identify colors? Yes No If yes, which? _____

Can your child identify numbers? Yes No Letters? Yes No
Does your child like to draw/color? Yes No
Is your child learning to read? Yes No

INTERESTS AND HOBBIES

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

Does your child watch TV? Yes No
If yes, how much? _____ how often? _____ viewing distance? _____
Does your child spend time using computer/video games? Yes No
If yes, how much? _____ how often? _____ viewing distance? _____

What other activities occupy your child's leisure time? _____

What does your child find most rewarding? _____

Are there any activities your child would like to participate in, but doesn't? Yes No

If yes, explain: _____

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.):

Give a brief description of your child's personality: _____

Is there any other information you feel would be helpful/important in our examination of your child?

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

We need a minimum of 15 minutes to review this information; therefore, we require that you arrive no later than 15 minutes prior to your scheduled appointment. If your child wears glasses, please bring them to the appointment. If you have a written copy of the prescription, please bring that as well.

Please be aware that we will not be dilating your child's eyes or using drops at the evaluation. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.