



Student 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? _____

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:

Illness/Injury	Age	Type of Severity	Complications (if any)

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: _____

List any prescription or over-the-counter medication(s) being taken, dosage, name and 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: _____

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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_____	_____	_____
_____	_____	_____

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? _____

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 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 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

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 at school or at home? 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? _____

Does your child need to spend a lot of time/effort to maintain this level or performance? Yes No

How much time on average does your child spend each day on homework? _____

How much assistance is given by a parent? _____

Specifically describe any school difficulties: _____

Possible reasons for difficulties? _____

What subjects are easy for your child? _____

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

Has a grade been repeated? _____ If yes which grade? _____

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes No

If yes, 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

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. If your child wears contact lenses, please have the doctor that fit the lenses fax us a copy of both the glasses and contact lens prescription.

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.