Date: _____

Student History Form

GENERAL INFORMATION

Child's Full Name:_____ Goes by: _____

DOB _____ Child's Age: _____ Gender: ☐ Male ☐ Female

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 Name: _____
Occupation: _____
Cell phone: _____
Work phone: _____
Email: _____

Father's Name: _____
Occupation: _____
Cell phone: _____
Work phone: _____
Email: _____

School Name & City: _____
_____
Teachers Name: _____
Child's grade in school: _____

How did you hear about our center? _____

Who is your medical insurance carrier? _____

PRESENT SITUATION

Reason for evaluation: _____

_____

List any observations 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? _____

_____

What is the child's awareness of the problem? _____

_____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, that the child has experienced:

Illness/Injury	Age	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 ☐ Other: _____

_____

Please list any psychological or educational tests performed: _____

_____

_____

_____

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

_____

_____

Does the child suffer from chronic health problems such as asthma, diabetes, allergies or ear infections?

_____

Has the child received any other services such as OT, PT, learning center or tutoring, sensory integration, auditory or speech therapy? ☐ 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 city: _____
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 by an eye doctor at any time for your child? ☐ Yes ☐ No
If yes, explain: _____
_____

Was the treatment program followed? ☐ Yes ☐ No
Was the treatment effective? ☐ Yes ☐ No
Have vision therapy services been pursued previously? ☐ Yes ☐ No
If yes, explain: _____

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

Name	Age	Visual Condition/Treatment

DEVELOPMENTAL HISTORY

Was your child adopted? ☐ Yes ☐ No Age at time of adoption: _____
Length of pregnancy: _____ Natural, C-Section: _____
Were fertility treatments used (such as IVF)? _____
Was your child a twin or multiple birth? _____

List any medications taken during pregnancy: _____
Complications before, during or following delivery for:

- Mom: _____
- Baby: _____

Were forceps or suction used? _____
Induction/Pitocin used? _____
Additional information regarding pre/post natal development: _____
_____

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 orthotics? ☐ Yes ☐ No

Which hand does your child use for:
Eating? _____ Writing? _____ Throwing? _____
Has a dominant hand been established? ☐ Yes ☐ No
Was any guidance given? ☐ Yes ☐ No
Which foot is used 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 sports, or athletics? ☐ Yes ☐ No
Please list: _____
Does he/she enjoy music? ☐ 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 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? ☐ Yes ☐ No

INTERESTS AND HOBBIES

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

How much time does your child spend in front of a screen (TV, iPad, computer, smart phone, video games, etc.)? _____
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

Additional home information (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 evaluation of your child?
_____
_____
_____