Vision Learning Center™ - Child's Development al History Form

Child's Name ______________________________ Birth Date ___ / ___ / ___ Age:__________
Nickname ____________________School ______________________________Grade ____________
Mother's Name ______________________________ Daytime Phone ______________________
Father's Name ______________________________ Daytime Phone ______________________
Guardian's Name ____________________________ Daytime Phone ______________________
Sibling's Names & Ages ____
____

DEVELOPMENTAL & BEHAVIORAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ If no, how many weeks early? _______ Birth weight ________
Normal birth? Yes ☐ No ☐ If no, please list any complications before, during or immediately following delivery ____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? ____________
Did your child creep (on all fours)? Yes ☐ No ☐ At what age? ________________
At what age did your child walk? ______________At what age did your child first speak?____________
Was early speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development? Yes ☐ No ☐
If yes, why? ____
Has there been any injuries to the head, eyes, ears or neck? Yes ☐ No ☐ When?________________
Describe Injury:____
Hand preference was clearly indicated at what age? _________ R L or Both (Please circle)
Are there any indications of hearing problems? Yes ☐ No ☐
Has a neurological, psychological, occupational therapy, physical therapy, speech, or hearing evaluation been performed in the past?

TYPE OF EVALUATION	DATE	BY WHOM	DIAGNOSIS / RESULTS

Pediatrician ____Last Visit ________________

ACADEMIC HISTORY

Age at time of entrance to: Pre-school ____________ Kindergarten ____________ First Grade _______
Specifically describe any school difficulties: ______________________________________
____
Has your child changed schools often? Yes ☐ No ☐ If yes, when? ________________________
Has a grade been repeated? Yes ☐ No ☐ If yes, which and why? ________________________
Is your child currently being evaluated for special education services? Yes ☐ No ☐ If so, when is your ARD Meeting scheduled? ___________ Is your child already on a 504 Plan or IEP? Yes ☐ No ☐
If yes, circle which one and list the qualifying label used? ______________________________
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? ____
Where and from whom? ____________________________________How long? ______________
Results: ____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Does your child like to read? Yes ☐ No ☐ Voluntarily? Yes ☐ No ☐
Does your child like school? Yes ☐ No ☐

WHICH CLASS SUBJECTS ARE:

Above average: ______________________________

Average: ______________________________

Below average: ______________________________

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments? ___________
To what extent do you assist your child with homework? ______________________________
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐
Child's favorite subjects? ______________________________

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☐ No ☐ If yes, what? ________________________
Are there any behavior problems at home? Yes ☐ No ☐ If yes, what? ________________________
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐ Can your child sit still for long periods? Yes ☐ No ☐

FAMILY AND HOME

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐ If yes, at what age? _____
Was counseling / therapy undertaken? Yes ☐ No ☐ If yes, is it still on-going? Yes ☐ No ☐
Does your child seem to have adjusted? Yes ☐ No ☐ Is family life stable at this time? Yes ☐ No ☐

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? __________ How much & often? ____________________
Does your child spend time using computers? Yes ☐ No ☐ If yes, how much & often? ____________
Does your child spend time using video games? Yes ☐ No ☐ If yes, how much & often? __________
Are there any activities your child would like to participate in, but doesn't? Yes ☐ No ☐
Please explain ______________________________
Is your child seriously involved with athletics? Yes ☐ No ☐
Which sports does he/she play seriously (list all)?______________________________
____
Do you feel they are achieving up to your potential in these sports? Yes ☐ No ☐ If not, please describe ______________________________
____
What other activities occupy your child's leisure time? ______________________________
____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON AND SHARE ANY OTHER INFORMATION YOU FEEL WOULD BE IMPORTANT IN THE TREATMENT OF YOUR CHILD: ________________________
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