



Pre-Kindergarten 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: _____
(if applicable) _____

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? _____

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

Name	Age	Visual Condition/Treatment
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_____	_____	_____
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_____	_____	_____
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MEDICAL HISTORY

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

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

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

If yes, explain: _____

When was your last eye exam? _____

Clinic name and address: _____

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

At what age were they first worn? _____

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

Was the treatment program followed?	Yes	No
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Was the treatment effective?	Yes	No
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Has a vision therapy program ever been recommended?	Yes	No
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o If yes has the program been completed?	Yes	No
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Does your child verbalize any problems/complaints about his/her vision 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: _____

DEVELOPMENTAL HISTORY

List any medications taken or complications during pregnancy:

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

Complications before, during or following delivery: _____

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 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? _____

Your child's first words were at 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

General Growth/development: Normal Delayed

Has your child undergone any of the following testing/treatment?

Educational: Yes No **Neurological:** Yes No **Psychological:** Yes No

Occupational: Yes No **Speech/Auditory:** Yes No **Physical:** Yes No

If yes, please list all previous evaluations done on your child:

Doctor/Institution	Date(s)	Type of Evaluation	Results/Treatment

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 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 that would be helpful/important in our evaluation or treatment of your child? _____
