Date: _______________

Preschool 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?
____

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

Last Medical Exam was on ____/____/_____ Doctor: ____
Immunizations up to date? ☐ Yes ☐ No Comments: ____________________________________
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 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

Does your child verbalize any problems/complaints about his/her vision? ☐ Yes ☐ No
If yes, explain: ______________________________
____

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: ______________________________
____

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 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

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?

☐ Above Average ☐ Average ☐ Below Average

Was there ever any reason for concern over your child's general growth or development? __________
____

Has the child received any other services such as OT, PT, sensory integration, auditory or speech therapy?
☐ Yes ☐ No If yes, explain: ____
____
____

What things can your child do very well? ______________________________________
____
What things 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 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?
____
____
____