

Patient Name _____

History of Child's Development

If the answer to any of the questions below is "no," please explain.

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Was pregnancy & delivery with this child normal, full term & free of complications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did the child crawl/creep by 8-10 months and walk by 12-18 month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did your child speak single words (<i>mama, daddy, dog</i> , etc.) by 18 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did your child combine words to speak simple phrases (e.g. <i>daddy go</i>) by age 2? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child automatically recognize all his letters and numbers? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to any of the following questions is "yes," please explain.

- | | | |
|---|--------------------------|--------------------------|
| 6. Did your child have frequent ear infections before age three? Ear tubes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Did he/she experience any serious accidents or illnesses that required hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did your child have an illness complicated by a prolonged high fever greater than 104°? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Did he have an accident that could have resulted in potential head trauma or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your child have any hearing loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does your child sometimes have difficulty understanding what you say? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does your child sometimes have difficulty remembering simple instructions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your child now or has he/she in the past received any speech therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has your child been diagnosed with ADD or ADHD?
<i>Please list any medication your child takes for ADD/ADHD:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have teachers suggested that your child might have ADD or ADHD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does your child receive any special educational services at school, such as a tutor or para, resource room, Title I, special ed, or modifications from an IEP or 504 plan?
<i>Please explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has your child been diagnosed with any neurological, psychological, behavioral or emotional disorders such as seizures, autism, Asperger's Syndrome, depression, anxiety, bipolar disorder, schizophrenia, post-traumatic stress, phobias, panic or obsessive-compulsive disorders?
<i>Is so, please explain and list any related medications the child is taking:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Please explain any other concerns that are pertinent to your child's development, vision, or education: | | |