ELLICOTT CITY
TOTAL EYE CARE

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Developmental Questionnaire

Child's Name:_____ Sex: _____ Age: _____ DOB: _____ Date: _____
Father's Name:_____Home Phone: _____Work Phone:_____
Mother's Name:_____Home Phone: _____Work Phone:_____
Home Address: _____
Referred by:_____
Reason for Referral: _____
What do you want to find out from the exam? _____

Family

1. Father's occupation: _____ Marital status:_____ Grade completed:_____
2. Mother's occupation: _____ Marital status:_____ Grade completed:_____
3. Languages spoken in home: _____
4. Siblings (age and sex) _____

Developmental History

1. Is the child adopted? _____ If yes, does the child know? _____ Age when adopted?_____
2. Was pregnancy full term? _____ Child's weight at birth:_____
3. Complications before, during, following delivery? _____
4. Was child exposed to: □ Drugs in utero □ Alcohol □ Nicotine
5. At what time did the following occur:
   Creeping (stomach off floor) :_____ Crawling (stomach on floor) :_____ Sitting alone :_____
   Walking alone:_____ Feeding self:_____ Voluntary bladder control:_____
   Tendancy to show handedness:_____
6. Has anyone attempted to change child's handedness? _____

Medical History

1. Has your child had any serioue accidents, operations or unusual illnesses? If so, please specify:
_____
_____
_____
2. List any allergies: _____
3. Medications/vitamins currently being used: _____
4. Last medical exam: _____
   What were the recommendations? _____
   Name of Pediatrician:_____
   Does test taking appear to cause anxiety?_____
5. Has your child or family been referred for counseling? _____
   If so, what was the reason for the referral? _____
   Was the therapy successful? _____

Vision Care

Last eye exam: _____ Location/Doctor:_____

Does your child currently wear glasses? □ Yes □ No If yes, how old are they? _____

Has your child meen treated with a patch or eye drops for Amblyopia? _____

If yes, describe the treatment plan: _____

Has your child reported any of the following?

□ Headaches If yes, when?_____

□ Blurred Vision _____

□ Tired Eyes _____

□ Double Vision _____

□ Light Sensitivity _____

Have you noticed any of the following while observing your child?

□ Squinting
□ Close/cover one eye
□ Eye rubbing
□ Excessive blinking
□ Reverses words/letters
□ Moves lips while reading
□ Moves head while reading
□ Tilts head while reading
□ Loses place when reading
□ Writes or prints poorly
□ Difficulty copying from blackboard
□ Tires when reading/doing homeword
□ Hold his/her book too close when reading
□ Skips words or rereads
□ Eye turning inward/outward
If do, one eye or both? _____
Distance or near? _____

General Development Skills

1. At what age did your child:
   Speak first sentance _____ Ask first questions _____
2. Was there another method of communication prior to speech? _____
3. Does your child have a speech or language deficit? _____
4. Has your child had speech therapy? _____
5. Has your child had physical therapy? _____ Occupational therapy? _____
   Was therapy succesful? _____

General Health

1. Does your child sleep through the night? _____
2. Current hours of sleep per night? _____
3. Does your child have a good diet? _____
4. Does your child eat fruits and vegetables? _____
5. Does your child take vitamin supplements? _____
6. Is there a high desire for sweets or junk food? _____
7. Are there any food allergies? _____ If yes, please explain: _____
8. Is your child on a restricted diet? _____ If yes, please explain: _____

Family and Home

1. What responsibilities does your child have at home? _____
2. Can your child carry out these responsibilities independently? _____
3. Describe special interests/hobbies: _____
4. State any tensional behavior such as nail biting, eye blinking, excessibe eye rubbing, tantrums or tongue chewing _____
5. What discipline is most effective in guiding your child? _____
6. What adults besides the parents plan an active part in guiding your child? _____

School Information

Please list the schools your child has attended, beginning with their current school (including home school):

Name	Location	Grade Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Does your child like school? _____ Is their attendance regular? _____
2. Has your child ever been retained? _____ If yes, what grade? _____
   How did your child react to retention? _____
3. What is the structure of the school (traditional, open classroom, etc.) _____
4. Which subject does your child enjoy the most? _____
5. How do you think your child performs in the following areas?

Reading comprehension	very good	adequate	fair	inadequate	poor
Sight vocabulary	very good	adequate	fair	inadequate	poor
Reading speed	very good	adequate	fair	inadequate	poor
Spelling	very good	adequate	fair	inadequate	poor
Handwriting	very good	adequate	fair	inadequate	poor
Expressing thoughts verbally	very good	adequate	fair	inadequate	poor
Expressing thoughts through writing	very good	adequate	fair	inadequate	poor
Math concepts	very good	adequate	fair	inadequate	poor
Attention span	very good	adequate	fair	inadequate	poor
Ability to follow written directions	very good	adequate	fair	inadequate	poor
Ability to follow verbal directions	very good	adequate	fair	inadequate	poor

6. Does your child memorize answers or do they think through a problem to obtain the solution?
   _____
7. What is your child's general attitude towards present school teachers? _____
8. What is your child's attitude towards teachers in general? _____
9. Type of teacher to whom your child is most responsive (i.e. male, female, strict, flexible etc.):
   _____
10. How would you rate your child's popularity among their classmates (i.e. ignored, rejected, accepted etc.):
    _____
11. Does the school consider your child to have a learning problem? _____ Explain: _____
12. Does the school consider your child to have a discipline problem? _____ If yes, please describe:
    _____
13. Has your child had any previous testing done at the school level? _____ If yes, please describe:
    _____
14. Does your child like to read? _____ If yes, what types of materials? _____
15. Does your child read as well as expected? _____

General Movement

1. Is your child physically active? _____
2. List team sports: _____
3. List individual sports: _____
4. Can your child catch a ball? _____ Throw a ball? _____
5. Would you consider your child to have good rhythm? _____
   Is your child clumsy? _____ Is your child coordinated? _____
6. Does your child avoid sports? _____

Behavioral Characteristices

The following is a list of characteristics that can often be observed in children. Please circle the appropriate response as they apply to your child.

Cries	most often	sometimes	rarely	unknown
Daydreams	most often	sometimes	rarely	unknown
Is friendly	most often	sometimes	rarely	unknown
Gets in fights	most often	sometimes	rarely	unknown
Is happy/light-hearded	most often	sometimes	rarely	unknown
Interacts well with adults	most often	sometimes	rarely	unknown
Has to be prodded to get things done	most often	sometimes	rarely	unknown
Follows through on tasks	most often	sometimes	rarely	unknown
Listens to reason	most often	sometimes	rarely	unknown
Nervous, irritable	most often	sometimes	rarely	unknown
Obeys	most often	sometimes	rarely	unknown
Is honest	most often	sometimes	rarely	unknown
Talks back	most often	sometimes	rarely	unknown
Has temper tantrums	most often	sometimes	rarely	unknown
Is timid or shy	most often	sometimes	rarely	unknown
Has strong fears	most often	sometimes	rarely	unknown
Becomes frustrated	most often	sometimes	rarely	unknown
Is dominated by other children	most often	sometimes	rarely	unknown
Takes lead with peers	most often	sometimes	rarely	unknown
Plays with children of same age	most often	sometimes	rarely	unknown
Plays with children of older age	most often	sometimes	rarely	unknown
Plays with children of younger age	most often	sometimes	rarely	unknown

Are any of the above behaviors significantly different at home vs. at school?

_____

Please describe any other characteristics of your child that we should be aware of in order to meet their needs as fully as possible:

_____

_____

_____

Did you answer all four pages? Thank you.

Signature _____

Relationship to child _____

Date _____