History Questionnaire – Children

Forename: _____ Surname: _____ DOB: _____
Mother: _____ Tel: _____
Occupation: _____ E-mail: _____
Father: _____ Tel: _____
Occupation: _____ E-mail: _____
Address Line 1: _____ Address Line 2: _____
Town/County: _____ Postcode: _____

SCHOOL INFORMATION		GP INFORMATION	
Class teacher:		Doctor:	
School:		Surgery:	
Street:		Street 1:	
Town:		Street 2:	
Postcode:		Town:	
Head teacher:		Postcode:	

MAIN REASON FOR VISUAL ASSESSMENT

Who recommended our services to you? _____

Is there any evidence from school, or special testing, that some visual difficulties may be present? Yes/No
If yes, please specify:

Why do **you** feel that your child needs a visual examination?

VISION

Date of most recent visual exam: _____ Where? _____
Reason for that examination: _____
Were glasses prescribed? Yes No When are they worn? _____
When were glasses first prescribed? _____
Has your child received any eye exercises or vision therapy? If yes, when? _____

FAMILY VISUAL CONDITIONS

If your child has any brothers or sisters, please list their names, age and any visual condition below:

Name	Age	Visual condition

Parents' visual conditions: Mother: _____ Father: _____
Has anybody in the family received vision training/eye exercises? Yes No
Has anybody in the family had learning difficulties? Yes No

Who?	Describe the exercises/difficulties

HEALTH

Briefly describe your child's physical condition: _____

Has your child had any hearing difficulties? Yes No When? _____

Ear infections? Yes No When? _____

Has your child received antibiotics? Yes No When? _____

Does your child have any allergies? Yes No Please specify: _____

Medications your child is currently using: _____

For what condition? _____

List any severe illnesses your child has had and when: _____

Accidents: _____

Has your child shown any food intolerances/allergies? Yes No _____

Does your child take any nutritional supplements? Yes No _____

Details from any of the above items:

DEVELOPMENT

Did the mother have any health problems during pregnancy? Yes No (give details below)

Did the mother take antibiotics? Yes No

Were there any doubts regarding foetal development? Yes No

Was the child born early/late? No Early Late _____ weeks

Was the baby large or small? Average Large Small _____ lb _____ oz

Was the duration of labour normal? Yes No _____ hours

Were there any complications during birth? Yes No

Did the child show any feeding problems during early infancy? Yes No

Did the child show any feeding problems during late infancy? Yes No

Were there any delays in the following areas of development:

Support of head? Yes No

Unsupported sitting? Yes No

At what age did your child: Crawl (all fours): _____ Walk: _____ Talk: _____

As an infant was your child over- or under-active? (specify) Yes No _____

Details from any of the above items:

CURRENT ABILITIES

Please score the following from 1 to 6 (1 for very poor, 6 for very good).

Activity	Score	Comments
Running:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Balance:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Ball skills:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Fine finger control:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Verbal language skills:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Listening skills:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Reading:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Writing:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Spelling:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	
Maths:	1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6	

Which hand does your child use for writing: Right Left

Further comments on any of the above:

SCHOOL HISTORY

At what age did your child first attend school?

When did your child start at his/her current school?

Has a year been repeated? Yes No If so which year?

Does he/she appear to be under extreme pressure when doing schoolwork? Yes No

Do you experience any difficulty getting homework/reading done? Yes No

Does your child like school? Yes No Does your child like the teachers? Yes No

Comments on any of the above:

Has your child had any special tutoring? Yes No

When?	With whom?	Address

What improvements did you notice?

EDUCATIONAL ASSESSMENTS

Has your child had a learning assessment with an Educational Psychologist or specialist teacher? Yes/No

When?	With whom?	Address

(Please send a full copy of the report in advance of the appointment.)

BEHAVIOUR DIFFICULTIES

Does your child show any behaviour problems at home or at school? Please give details below:

PERSONALITY

Please give a description of your child's personality:

OTHER INFORMATION?

Is your child receiving advice from any other specialists not noted above? Yes No
Is there any further information you intend to send me before the assessment? Yes No

Signed: _____ Date: _____
Name: _____ Relationship to child: _____

Consent for disclosure of information:
We cannot disclose information without your prior signed approval. If you would like us to be able to share information with anyone other than the parents/guardians named in the first section of this questionnaire, please ask for a copy of our authorisation form.

Please return the completed questionnaire at your earliest convenience, enclosing a copy of any educational assessment report, and any other reports that might be of interest. If your child has difficulties with drawing and writing, please bring along samples. We will be looking forward to seeing all of you at the appointed time.

My priority on meeting your child will be to help your child settle to the assessment routine. If you wish to speak to me before I start the assessment, please arrange a time for me to phone you.

End - thank you for your help.