CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please complete and return. THANK YOU.

GENERAL INFORMATION

Child's Full Name_____Age_____Birth Date_____ Male__ Female__

School_____School Address_____

_____

Grade____Teacher_____Principal_____

Is your child especially afraid of doctors? Yes__ No__

Were you referred to our office? Yes__ No__ If yes, whom may we thank?_____

Address_____

Names of Parents or Legal Guardians_____

MEDICAL HISTORY

Date of most recent medical examination:_____Doctor's Name:_____

Reason:_____Results:_____

Child's current state of health:_____

Medications currently using, including vitamins and supplements_____

_____

For what condition(s)?_____

List illnesses, bad falls, head injuries, high fevers, etc._____

Complications and ages_____

Is your child generally healthy? Yes__ No__

Are there any chronic problems like asthma, hay fever, allergies? Please List_____

_____

Has a neurological evaluation been performed? Yes__ No__ By whom?_____

Results:_____

Has a psychological evaluation been performed? Yes__ No__ By whom?_____

Results:_____

Does your child currently receive:

Occupational therapy services? Yes__ No__ By whom?_____

Results_____

Physical therapy services? Yes__ No__ By whom?_____

Results_____

Speech therapy services? Yes__ No__ By whom?_____

Results_____

Is there any history of the following?

	Patient	Family	Who?		Patient	Family	Who?
Diabetes	_____	_____	____	Glaucoma	_____	_____	____
Eye turn	_____	_____	____	Amblyopia	_____	_____	____
MS	_____	_____	____	Seizures	_____	_____	____

Any other conditions?_____

Is your child: Moderately active__ or Extremely active__

Are there periods of very high energy? Yes__ No__ Low energy? Yes__ No__

DEVELOPMENTAL HISTORY

Full term pregnancy? Yes__ No__ Normal Birth? Yes__ No__ Birth weight_____

Any complications before, during, or immediately after delivery?_____

At what age did your child walk?_____Was child active?_____

First words at age:_____

Was speech clear to others? Yes__ No__ Is it clear now? Yes__ No__

Which is your child's dominant hand? Right__Left__

VISUAL HISTORY

Date of last eye exam:_____Doctor's Name_____

Results_____

Were glasses prescribed? Yes__ No__ Are they worn? Yes__ No__ For near or distance or both?_____

PRESENT SITUATION

List any complaints your child makes concerning his/her vision_____

_____

Television viewing: How much?_____How often?_____Viewing distance_____

Video game playing: How much?_____How often?_____Viewing distance_____

Are there any activities your child would like to participate in but doesn't? Please explain._____

_____

ACADEMIC HISTORY

Age at time of entrance to Kindergarten_____

Does child like school? Yes__ No__ Teacher? Yes__ No__

Schoolwork is: Above average__ Average__ Below Average__

Does your child spend a lot of time and effort to maintain this level of performance? Yes__ No__

How much time on average does your child spend each day on homework assignments?_____

To what extent do you help your child with homework?_____

Do you feel your child is achieving up to potential? Yes__ No__

Does the teacher feel your child is achieving up to potential? Yes__ No__

Does your child like to read? Yes__ No__ Voluntarily? Yes__ No__

Indicate any problems in the following areas:

__Reading	__Comprehension	__Reversals
__Writing	__Avoidance of school work	__Motivation/Behavior
__Overly active	__Low self-esteem	__Math
__Poor memory	__Spelling	__Attention/Concentration
__Slow work	__Other_____	

Has a grade been repeated? Yes__ No__Which?_____

Does he/she seem to be under extreme tension or pressure when doing schoolwork? Yes__ No__

List any past or current help, training or tutoring utilized for the above problems:

_____

GENERAL BEHAVIOR

Please list any behavior problems at:

School:_____Home:_____

What causes these problems?_____

Child's reaction to fatigue: Sad__Irritable__Other___ Impulsive? Yes__ No__ Constant motion? Yes__ No__

FAMILY AND HOME

Please indicate which adults he/she lives with? Mother__ Father__ Stepmother__ Stepfather__ Foster Parents__ Grandmother__ Grandfather__ Aunt__ Uncle__ Other Caretaker_____

Does your child spend a lot of time with any other person, not in the home? Yes__ No__

Please explain_____

Has your child been through a traumatic family situation (such as divorce, parental illness)? Yes__ No__

Was counseling or therapy undertaken? Yes__No__

Is it still ongoing? Yes__ No__ Is family life stable at this time? Yes__ No__

If no please explain_____

How does he/she get along with:

Parents_____

Siblings_____

Classmates_____

Playmates_____

Give a brief description of your child as a person:_____

_____

_____

Please provide any additional information you feel would be helpful in our treatment of your child:_____

_____

Children's Symptom Checklist

Name_____Date_____

Please complete this questionnaire. After each symptom listed, circle the number that best describes how often you experience that particular problem.

0=Never, 1=Seldom, 2=Occasionally, 3=Frequently, 4=Always

1.	Blurred vision at near	0	1	2	3	4
2.	Double vision	0	1	2	3	4
3.	Headaches associated with near work	0	1	2	3	4
4.	Burning, stinging, watery eyes	0	1	2	3	4
5.	Rubbing or blinking of eyes	0	1	2	3	4
6.	Words run together when reading	0	1	2	3	4
7.	Falling asleep when reading	0	1	2	3	4
8.	Skipping or repeating lines when reading	0	1	2	3	4
9.	Difficulty copying from the chalkboard	0	1	2	3	4
10.	Head tilt or closing one eye when reading	0	1	2	3	4
11.	Reversals of letters like b,d,p,q	0	1	2	3	4
12.	Omitting small words when reading	0	1	2	3	4
13.	Reading comprehension declining over time	0	1	2	3	4
14.	Inconsistent/poor sports performance	0	1	2	3	4
15.	Holding reading material too close	0	1	2	3	4
16.	Short attention span	0	1	2	3	4
17.	Difficulty completing assignments in reasonable time	0	1	2	3	4
18.	Avoiding sports and games	0	1	2	3	4
19.	Car sickness/motion sickness	0	1	2	3	4
20.	Forgetful, poor memory	0	1	2	3	4

For Office Use Only		0	1	2	3	4	Total
Pre-Treatment Totals	=						
Post-Treatment Totals	=						

Teacher Questionnaire

To the teacher of _____Grade_____School_____

The child named above is receiving vision care in our office. In order to address the impact of vision problems on classroom performance, we would like your observations of this child's behavior in school.

It has been shown that the teacher is frequently the best observer for identifying vision problems that tend to interfere with schoolwork. The following checklist identifies many of the observable clues and symptoms that are often observed in a child with a vision problem. Please read through this list and check items that you have noted to occur ***frequently*** in this child's case.

Appearance of Eyes

- ❑ Reddened eyes or lids
- ❑ Excessive tearing or rubbing of eyes
- ❑ Blinks excessively

Refractive Error or Eye Focusing (Accommodation) Problem

- ❑ Blinks excessively during near tasks
- ❑ Frowns, scowls, or squints to see blackboard
- ❑ Avoids close work
- ❑ Fatigues easily during visual tasks
- ❑ Rubs eyes during or after visual activity
- ❑ Complains of blur while reading or writing
- ❑ Comprehension is poor when reading or performing near tasks

Eye Tracking (Ocular Motility) Problem

- ❑ Skips or rereads words or letters
- ❑ Rereads lines or phrases
- ❑ Mistakes words with similar beginnings or endings
- ❑ Uses finger or marker when reading
- ❑ Loses place often when reading
- ❑ Repeatedly omits "small" words
- ❑ Moves head excessively as reads across page

Eye Teaming (Binocularity) Problem

- ❑ Complains of seeing double

Eye Teaming (Cont.)

- ❑ Covers or closes one eye
- ❑ One eye turns (in, out, up, or down)
- ❑ Tilts or turns head to one side
- ❑ Squints, closes or covers one eye
- ❑ Complains of letters or lines "floating," "running together," or "jumping around"
- ❑ Reports confusion of what is seen

Visual Information-Processing Problem

- ❑ Confuses similar words
- ❑ Fails to recognize same word in next sentence or page
- ❑ Confuses minor likenesses and differences
- ❑ Makes errors in copying from chalkboard or reference book
- ❑ Difficulty following instructions
- ❑ Difficulty completing assignments in time allotted
- ❑ Poor printing or handwriting
- ❑ Short attention span, distractible
- ❑ Says words aloud or moves lips as reads
- ❑ Reverses letters, numbers or words
- ❑ Poor ability to remember what is read
- ❑ Poor eye-hand coordination
- ❑ Repeatedly confuses right-left directions
- ❑ Poor recall of visual tasks

Please comment of the following:

Does this child have any academic problems? Yes____No____
If so please explain (e.g. subject material, behavior, etc.)_____
_____
_____
_____
_____

Is (s)he in the top third, middle third, or lower of his/her class?_____

How does academic achievement compare with potential?_____
_____
_____
_____

Is this child reading below, above, or on grade level?_____

Please check any areas of difficulty:

- ❑ Vocabulary
- ❑ Reading Fluency
- ❑ Ability to stay on task
- ❑ Math Skills
- ❑ Word Recognition
- ❑ Fine Motor Skills
- ❑ Gross Motor Skills
- ❑ Comprehension
- ❑ Spelling
- ❑ Penmanship
- ❑ Silent Reading
- ❑ Memory
- ❑ Written Work

Do you feel there are any factors that may be interfering with academic achievement? Please explain._____
_____
_____

Any other observations and/or comments that you feel may be helpful to us would be appreciated._____
_____
_____

May we contact you if further information is required? If so, please provide a telephone number at which you can be reached and the best time to call.

Teacher_____Phone_____
Best time to call_____Email address_____
School Name_____
School Address_____
City_____State_____Zip_____
Signature_____Date_____

I hereby give my consent to release the above information

_____ _____
PARENT OR GUARDIAN SIGNATURE DATE