Boulder Valley VISION THERAPY

CHILDRENS' VISION QUESTIONNAIRE

*Please fill complete this questionnaire and return it to our office **PRIOR** to your appointment in the envelope provided. THANK YOU.*

Child's Name: _____

Birthdate: _____ Age: _____ years _____ months

GENERAL INFORMATION:
Whom may we thank for this referral? _____ Phone: _____

Address: _____

Name and address of school: _____
Grade: _____ Teacher(s): _____

Please list the names and birth dates of your family:
Father/Caretaker _____ Birth Date _____

Mother/Caretaker _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Preferred Contact Information (e-mail/ phone#): _____

MEDICAL HISTORY:
Pediatrician's Name: _____ Date of last Evaluation: _____
For what reason?_____
Child's Current state of health: _____
_____
Medications and vitamins/supplements: _____
Medical Conditions: _____
Are immunizations current? _____ Any reactions to immunizations? _____
Are there any chronic problems (ear infections, allergies, asthma)? _____
List illness, bad falls, high fevers, etc:

Age	Condition	Severity	Complications

Has a neurological evaluation been performed? ☐ No ☐ Yes, Results: _____
Has a psychological evaluation been performed? ☐ No ☐ Yes, Results: _____

Has an occupational therapy evaluation been performed? □ No □ Yes, Results and Recommendations:

_____

Check the box if there is a history of these conditions. List the family member with the condition:

Diabetes □ No □ Yes, _____ **Crossed Eyes** □ No □ Yes, _____
Seizures □ No □ Yes, _____ **Eyes drift out** □ No □ Yes, _____
ADD/ADHD □ No □ Yes, _____ **Lazy Eye(amblyopia)** □ No □ Yes, _____
Multiple Sclerosis □ No □ Yes, _____ **Strabismus** □ No □ Yes, _____
Developmental Delays □ No □ Yes, _____ **Other:** _____
Chromosome Disorder □ No □ Yes, _____ _____
Learning Disability □ No □ Yes, _____ _____

NUTRITIONAL INFORMATION:

Current Diet: _____
Food Allergies: _____Typical Energy Level: _____

DEVELOPMENTAL HISTORY

Was this patient adopted? □ No □ Yes Full-term pregnancy: □ No □ Yes
List any pregnancy complications: _____
Normal birth: □ No □ Yes List any birth complications: _____
_____
Birth weight: _____ Apgar at birth: _____ Apgar at second check: _____
Any concern over general growth or development? _____
_____
Did your child creep (scoot on tummy)? □ No □ Yes At what age? _____
Did your child crawl (up on all fours)? □ No □ Yes At what age? _____
At what age did your child walk? _____ Any difficulty with speaking? □ No □ Yes
At what age did your child begin talking? _____ Is speech clear now? □ No □ Yes

VISUAL HISTORY

Has your child's vision been evaluated by an eye doctor? □ No □ Yes, Dr. _____
Date of last evaluation: _____ Reason for exam: _____
Results and recommendations: _____
Were glasses or contact lenses recommended? _____
Are they used? □ No □ Yes, when? _____
Is there a family history of vision problems? □ No □ Yes _____
List any complaints your child makes about their vision: _____
_____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____
How long has this problem been observed? _____
Are there any testing results that have indicated a visual disorder? □ No □ Yes, _____
_____
Give a brief description of your child as a person: _____
_____
_____
_____

Does your child report any of the following?

Symptoms	Yes	If yes, when?	Symptoms	Yes	If yes, when?
Headaches	☐		Eyes hurt	☐	
Blurred vision	☐		Eyes tired	☐	
Focus goes in and out	☐		Words move on page	☐	
Double vision	☐		Motion sickness	☐	
Dizziness	☐		Other complaints	☐	

Have you or anyone else noticed any of the following?

Symptoms	Yes	If yes, when?	Symptoms	Yes	If yes, when?
Red eyes	☐		Frequent blinking	☐	
Frequent eye rubbing	☐		Closing or covering one eye	☐	
Frequent styes	☐		Difficulty seeing at distance	☐	
Frowning	☐		Avoids reading	☐	
Light sensitive	☐		Head close to paper	☐	
Prefers being read to	☐		Tilts head when reading	☐	
Moves head when reading	☐		Vocalizes when reading silently	☐	
Confuses letter or words	☐		Tilts head when writing	☐	
Confuses left and right	☐		Loses place when reading	☐	
Reverses letters or words	☐		Skips or omits words	☐	
Rereads words	☐		Reads slowly	☐	
Uses finger to keep spot	☐		Poor reading comprehension	☐	
Writes slowly	☐		Writes poorly	☐	
Comprehension decreases over time	☐		Difficulty recognizing same word on the next page	☐	
Tires easily	☐		Frequent erasures	☐	
Poor memory	☐		Difficulty hitting a ball	☐	
Dislikes sports	☐		Difficulty catching a ball	☐	
Difficulty with scissors	☐		Poor fine motor skills	☐	
Short attention span	☐		Poor large motor skills	☐	
Avoids near tasks	☐		Poor test performance	☐	
Remembers better what hears than sees	☐		Poor eye-hand coordination	☐	

LEISURE ACTIVITIES

How much TV does your child watch? _____ Viewing distance? _____
How much time on computer? _____ Playing video games? _____
What activities does your child enjoy? _____
Are there activities that your child would like to participate in, but doesn't? _____
_____

SCHOOL

Age of time of entrance to: preschool _____ Kindergarten _____ First grade _____
Does your child like school? □ No □ Yes Has your child changed schools often? □ No □ Yes
Describe any school difficulties: _____
_____
Has a grade been repeated? □ No □ Yes, why_____
Does you child seem under tension or stress during school work? □ No □ Yes
Has your child had any tutoring therapy or remedial assistance? □ No □ Yes, _____
_____
Does your child like to read? □ No □ Yes Does your child read for pleasure? □ No □ Yes
What does your child enjoy reading? _____
What is your child's attitude toward school? _____
Which subjects are:
Above average: _____
Average: _____
Below average: _____
Does your child spend a lot of time and effort to maintain this level of performance? □ No □ Yes
How much time does your child spend on an average day of homework? _____
How much assistance do you give your child? _____
Is your child achieving up to their potential? □ No □ Yes
Does the teacher feel the child is performing at potential? □ No □ Yes
Are there any behavioral issues? _____
What is your child's reaction to stress? _____

FAMILY AND HOME

Who does your child live with? _____
Has your child been through a traumatic family situation? (divorce, loss, illness) □ No □ Yes
If yes, at what age? _____ Does your child seem to have adjusted? □ No □ Yes
Was counseling/therapy undertaken? □ No □ Yes, _____
How well does your child get along with peers and adults? _____

Is there any other information you feel would be helpful/important in our treatment of your child?

_____
_____
_____
_____
_____
_____
_____
_____