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# CHILDRENS VISION QUESTIONNAIRE

***Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. THANK YOU.***

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

## GENERAL INFORMATION

Whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____ Male ____ Female ____
Birth Date: _____ Age: _____years _____months
Name and address of school: _____
_____
Grade: ____ Teacher: _____ School Nurse: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

Please list the names and birth dates of your family:

| | NAME | | |
|---|---|---|---|
| Father/Caretaker | _____ | Birth Date | _____ |
| Mother/Caretaker | _____ | Birth Date | _____ |
| Sibling | _____ | Birth Date | _____ |
| Sibling | _____ | Birth Date | _____ |
| Sibling | _____ | Birth Date | _____ |
| Sibling | _____ | Birth Date | _____ |

## RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Social Security Number: _____ Driver's License #: _____
Email Address: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Social Security Number: _____ Driver's License #: _____
Email Address: _____

## MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____

Child's current state of health: _____
Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____
Are your child's immunizations up to date?_Yes ☐ No ☐

List illnesses, bad falls, high fevers, etc.:

| Age | Severe | Mild | Complications |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Has a speech evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Have any other evaluations been performed? Yes ☐ No ☐ Type? _____
By whom?_____ Results and recommendations: _____

Is there any history of the following? (please check all that apply)

| | Patient | Family | Who | | Patient | Family | Who |
|---|---|---|---|---|---|---|---|
| "Cross" eyed | ☐ | ☐ | _____ | Learning Disability | ☐ | ☐ | _____ |
| Chromosomal Abnormality | ☐ | ☐ | _____ | Amblyopia (lazy eye) | ☐ | ☐ | _____ |
| ADD/ADHD | ☐ | ☐ | _____ | Dyslexia | ☐ | ☐ | _____ |
| ASD | ☐ | ☐ | _____ | Epilepsy or Seizures | ☐ | ☐ | _____ |
| | | | | Type _____ | | | |

If other, please explain: _____

**HAS YOUR CHILD BEEN DIAGNOSED ON THE AUTISM SPECTRUM?** Yes ☐ No ☐
By whom?_____

**NUTRITIONAL INFORMATION**
Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Is your child active? Yes ☐ No ☐
moderately? Yes ☐ No ☐
extremely? Yes ☐ No ☐

## DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development?
Yes ☐ No ☐.
If yes, why? _____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____
Did your child creep (on all fours)? Yes ☐ No ☐ At what age? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐

## VISUAL HISTORY

Has your child's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____
Members of the family who have had visual treatment and the reason:

| Name | Age | Visual Situation |
|---|---|---|
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |

## PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? _____
_____

| Does your child report any of the following?: | Yes | No | If yes, when? |
|---|---|---|---|
| Headaches | ☐ | ☐ | |
| Blurred vision / focus goes in and out | ☐ | ☐ | |
| Double vision | ☐ | ☐ | |
| Eyes hurt | ☐ | ☐ | |
| Eyes tired | ☐ | ☐ | |
| Words move around on the page | ☐ | ☐ | |
| Motion sickness / car sickness | ☐ | ☐ | |
| Dizziness | ☐ | ☐ | |

List any other complaints your child makes concerning his/her vision: _____

_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING DURING NEAR VISION TASKS:

| | Yes | No | If yes, when? |
|---|---|---|---|
| Eyes frequently reddened | ☐ | ☐ | |
| Frequent eye rubbing | ☐ | ☐ | |
| Frequent sties | ☐ | ☐ | |
| Frowning | ☐ | ☐ | |
| Bothered by light | ☐ | ☐ | |
| Frequent blinking | ☐ | ☐ | |
| Closing or covering one eye | ☐ | ☐ | |
| Difficulty seeing distant objects | ☐ | ☐ | |
| Head close to paper when reading or writing | ☐ | ☐ | |
| Avoids reading | ☐ | ☐ | |
| Prefers being read to | ☐ | ☐ | |
| Tilts head when reading | ☐ | ☐ | |
| Tilts head when writing | ☐ | ☐ | |
| Moves head when reading | ☐ | ☐ | |
| Confuses letter or words | ☐ | ☐ | |
| Reverses letter or words | ☐ | ☐ | |
| Confuses right and left | ☐ | ☐ | |
| Skips, rereads or omits words | ☐ | ☐ | |
| Loses place while reading | ☐ | ☐ | |
| Vocalizes when reading silently | ☐ | ☐ | |
| Reads slowly | ☐ | ☐ | |
| Uses finger as a marker | ☐ | ☐ | |
| Poor reading comprehension | ☐ | ☐ | |
| Comprehension decreases over time | ☐ | ☐ | |
| Writes or prints poorly | ☐ | ☐ | |
| Writes neatly but slowly | ☐ | ☐ | |
| Does not support paper when writing | ☐ | ☐ | |
| Awkward or immature pencil grip | ☐ | ☐ | |
| Frequent erasures | ☐ | ☐ | |
| Tires easily | ☐ | ☐ | |
| Difficulty copying from chalkboard | ☐ | ☐ | |
| Difficulty recognizing same word | | | |

| | | | |
|---|---|---|---|
| on different page | ☐ | ☐ | _____ |
| Poor word attack skills | ☐ | ☐ | _____ |
| Difficulty with memory | ☐ | ☐ | _____ |
| Remembers better what hears than sees | ☐ | ☐ | _____ |
| Responds better orally than by writing | ☐ | ☐ | _____ |
| Seems to know material, but does poorly on tests | ☐ | ☐ | _____ |
| Dislikes / avoids near tasks | ☐ | ☐ | _____ |
| Short attention span / loses interest | ☐ | ☐ | _____ |
| Poor large motor coordination | ☐ | ☐ | _____ |
| Poor fine motor coordination | ☐ | ☐ | _____ |
| Difficulty with scissors / small hand tools | ☐ | ☐ | _____ |
| Dislikes / avoids sports | ☐ | ☐ | _____ |
| Difficulty catching / hitting a ball | ☐ | ☐ | _____ |
| "Stimming" behaviors | ☐ | ☐ | |

Please list _____

Sensory seeking behaviors or sensory avoidances _____

_____

**TELEVISION VIEWING/LEISURE TIME ACTIVITIES**

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____

_____

**SCHOOL**

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____

_____

Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____

Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐
What? _____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/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 assist 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 ☐

**GENERAL BEHAVIOR**
Are there any behavior problems at school? Yes ☐ No ☐
If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? sag ☐ irritable ☐ other ☐
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still for long periods? Yes ☐ No ☐

**FAMILY AND HOME**
Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____
Does your child spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____
Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: _____
Does your child seem to have adjusted? Yes ☐ No ☐
Was counseling /therapy undertaken? Yes ☐ No ☐
If yes, is it on-going? Yes ☐ No ☐
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____
How does your child get along with:
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes ☐ No ☐

If yes, who? _____

Did mother or anyone in mother's family have a learning problem? Yes ☐ No ☐

If yes, who? _____

Do any, or did any, of the other children in the family have learning problems? Yes ☐ No ☐

If yes, who? _____

To what extent? _____

_____

_____

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:** _____

_____

_____

_____

_____

**IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?**

_____

_____