Parents Questionnaire

Name____ **Birth date** _______________________________

Address____

School ____ **Grade**__________________________________

Teacher(s): ____

Parent's names: ____

Occupations: Mother: __________________________________ **Father:** __________________________________

A. Entering Complaint/Major Concern:

1) Please state briefly your main concern and the main problem your child is having:

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2) Who first noted possible visual difficulties? ____

3) Who referred you to our office? ____

B. Visual History

1) Is this your child's first visual examination? ____

2) If not, when was their last examination?

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Please describe any previous visual treatment your child has received, including glasses, vision therapy, patch, surgery, or medications.

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3) Please check any of the following that you or the teacher have noticed or that your child complains about:

___ blurred distance vision
___ double vision
___ Closes one eye when reading
___ eye turns in, out, up, down
___ fatigue during near visual tasks
___ squints or blinks excessively
___ holds book or paper too close
___ loss of place when reading
___ uses finger or underliner to read
___ poor eye-hand coordination

___ blurred vision during reading
___ words moving or running together
___ tilts head
___ frequent headaches
___ eye strain
___ red or teary eyes
___ avoids close work
___ skips or rereads lines
___ *frequent reversals*
___ *Trouble learning left from right*

___ *Reverses letters and numbers*
___ *Mistakes words with similar beginnings*
___ *Trouble learning basic math concepts*
___ *Poor reading comprehension*
___ *Poor recall of visually presented material*
___ *Trouble with spelling and sight vocabulary*
___ *Sloppy writing skills*
___ *Trouble copying from board to book*
___ *Erases excessively*
___ *Responds better orally than in writing*

C. Educational History

1) Has your child repeated any grades? ____

If yes, which one? ____

2) Is your child receiving any extra help in school or in any special classes? Please describe.

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3) Has there been any evaluations done at school or by school recommendation? (psychological, educational, speech/language, occupational therapy, neurological, medical)

If yes, please state when and describe the results

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4) Please check if there are difficulties in any of the following areas for your child:

___ reading ___ handwriting ___ math
___ spelling ___ copying from the board ___ attention span
___ behavior or motivation

5) Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

___ comprehension ___ word recognition ___ phonics
___ slow reading ___ loss of place ___ fatigue
___ uses finger ___ avoidance ___ comprehension declines the longer they read
___ my child has good comprehension when I read to him, but has difficulty with comprehension when reading on his/her own

6) Do you feel your child is performing up to his/her potential in school?

____

7) Does your child enjoy reading for pleasure?

____

D. Developmental History

1) Were there any complications with pregnancy or during birth? ______________________________
2) Was the child born prematurely? ________ If yes, How soon? ______________________________
3) Child's birth weight ______________________________
4) At what age did your child begin walking unassisted? ______________________________
5) At what age did your child begin to say 2 to 3 word phrases? ______________________________
6) Any speech problems now or in the past? ______________________________
7) Any problems with fine motor coordination?
____
8) Is your child clumsy or have difficulty with activities requiring good balance?
9) Does you child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc.? ____________________

E. Medical History

1) Have there been any severe childhood illnesses, injuries, or physical impairment?

____

If yes, please describe______________________________

2) Has your child had frequent ear infections? _________ If yes, what treatments have they undergone?
____

3) Any current health problems?
____

4) Taking any medications? _______ If yes, list drugs and doctor that has prescribed them:

____

5) Any significant allergies? Please describe:______________________________
____

F. Family History

1) Does anyone in the family have any of the following?

___ strabismus (crossed eyes) ___ amblyopia (lazy eye)
___ high nearsightedness, farsightedness, or astigmatism
___ learning or reading problems
___ eye disease (please list)
____