Vision Questionnaire – Child

Date of Appointment:_____

Please take some time to complete this Vision Questionnaire prior to your Visual Evaluation.

Child's Full Name:	**Home Address:**
Date of Birth:	**Home number:**
Name of School:	**Name of Teacher**
Grade:	**IEP: Y or N**

Parent/Guardian 1:	**Email:**
Cell number:	**Relationship to child:**
Work number:	**Occupation:**

Parent/Guardian 2:	**Email:**
Cell number:	**Relationship to child:**
Work number:	**Occupation:**

Developmental History: (please circle or answer below)

Family Doctor/ Pediatrician (name and phone number): _____

_____

_____

Full term Pregnancy? YES NO

Natural Birth OR C-section

Did the mother experience any complications during or after pregnancy? (i.e.- forceps, vacuum assisted delivery etc.) If yes please explain below.

YES NO

Was your child in any distress during or after birth? If yes please explain below.

YES NO

Did your child crawl as an infant? YES NO

If yes, was it for a short period of time? Were they more interested in standing or walking? At what ages did these developmental phases take place. Please mention if they crawled properly or had a variation of crawling (i.e. army crawl, bum scooting etc.)

Were there any difficulties with gross motor skills as an infant or child? Please describe.

Family and Home:

Please indicate which adult(s) he/she live with: (circle) Mother Father Stepmother Stepfather Grandmother Grandfather Others

Does your child primarily live in one household or split between two households?

Does your child have any siblings?

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Is family life stable at this time? Yes No

Has your child ever been through a traumatic family situation (such as divorce, family loss, abuse, parental illness or other emotionally traumatic events, etc.)?

Medical History

Describe your child's current health state.

List of current medications and associated conditions.

As an infant or currently, does your child suffer from any chronic problems such as ear infections, asthma etc. Also, describe if they used antibiotics frequently as a child.

Does your child have any previously diagnosed special needs conditions such as Autism, ADHD, depression/anxiety etc. Yes No

Name of conditions:

Has your child hit their head in the past, taken a bad fall, been in a car accident, or suffered from a head injury?

Has your child ever had a diagnosed concussion?

Is your child currently receiving or being assessed for additional services? What were the results and how often do you attend: (i.e. Speech and Language, Occupational Therapy, Physiotherapist, psychiatric care etc.)

Is your child involved in any extra-curricular activities or does he/she have any specific hobbies.

_____

_____

_____

_____

******Please observe your child for a few days prior to answering the questions below******

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

Physical Complaints

1	Headaches when reading or doing desk work.	
2	Car sickness	
3	Upset stomach during reading or school work.	
4	Exhausted after a day at school	
5	Complains of blurred vision even though the screenings at the school or pediatrician's office have been normal, or a routine eye examination has been normal	
6	Eyestrain during reading or desk work.	
7	When reading, see the print dance.	
8	When reading, sees the print run together	
9	Complains that the print is too small.	
10	Sees two of things when only one is there	
11	Covers an eye when trying to read.	
12	Tilts and turns head to side to ignore one eye when reading, writing or watching TV	
13	Squints when looking from near to far or from far to near	
14	Rubs eyes when reading	
15	Holds book too closely; face too close to desk surface.	
16	Moves closer and further away from the book, as if to "focus" it.	
17	One eye turns in or out.	
18	Your child has already been diagnosed with a Lazy Eye (amblyopia).	

19	Your child had surgery for a crossed eye but still has problems with either school or coordination.	

Physical Complaints Section Score: _____

Learning to Read

20	Very slow at sounding out words even when the "rules" are known; i.e., knows the letter sounds for "c," "a," and "t," but labors to sound out "cat."	
21	Omit small words.	
22	Repeat letters or syllables in a word.	
23	Read the first letter or two of the word and guess at the rest.	
24	Fails to recognize the same word in the next line.	
25	Can read a word that is isolated and large on a flash card, but can't recognize the same word when it's smaller or squeezed into a line of print	
26	Confuses likenesses and minor differences, such as substituting "what" for "that."	
27	Reverses letters or words, such as "b" for "d" or "was" for "saw."	
28	Need to use a finger to maintain place when reading.	
29	Gets lost when trying to sound out words of more than one syllable.	
30	Reading improves if you use a pickup stick or pen tip to point to the parts of the words for your child, reducing the need for accurate eye control.	

Learning to Read Section Score:_____

Reading to Learn

31	Reads well for a short time then begins to make careless errors	
32	Rapidly tires out and loses comprehension when reading	
33	Whispers to self while reading silently so the words can go in "through the ears."	
34	Your child can sound out or recognize the words but his comprehension is better when he uses his ears to listen to you read than when he uses his eyes to read himself.	
35	Avoid reading whenever possible.	

36	Reading comprehension is not as good as your child's intelligence would predict.	
37	Will not attempt books with smaller print	
38	Loves to be read to, but will not read himself	
39	Enjoys buying books, but never reads them.	
40	Takes forever to finish a book, even when interested.	
41	Counts pages before considering a book.	
42	Your child reads well, but reading skills don't reflect his/her intelligence and potential.	

Reading to Learn Section Score:____

Getting it on Paper

43	Makes errors in copying from desk to paper.	
44	Copying assignments takes forever.	
45	Handwriting is off the lines, going "up and down hill."	
46	When writing, words are poorly spaced.	
47	Your child is bright and reads well but struggles to get thoughts down on paper.	
48	In math, misaligns digits or columns.	
49	Copies words backwards; for example, was for saw.	
50	Confuses bs and ds.	
51	In math, becomes confused if there are too many problems on the same page.	
52	Can spell out loud but not when having to write the words.	
53	Makes errors when copying from reference book to notebook.	
54	Brain moves faster than hands. Your child is bright, but his/her hands are not.	
55	Leaves out letters or words when copying	
56	When writing, can't spell the same words that were known on the spelling test.	
57	Spells words like they sound rather than correctly	

Getting it on Paper Section Score:_____

Coordination and Sports (If a question applies to a sport you don't play, give yourself a score of 0)

58	Runs into things	
59	Stumbles, trips or falls.	
60	Clumsy. Poor balance.	
61	Awkward when moving	
62	Has/had difficulty in learning to ride a bike.	
63	Knocks things over	
64	Can't keep eye on the ball	
65	Catches "by feel," trying to grab the ball after it bounces off chest.	
66	Spends all time reading. Avoids exercise, especially ball sports.	
67	Glasses are rapidly becoming stronger.	
68	Can't hit a ball.	
69	In tennis, can't return lobed balls.	
70	In baseball or softball, misjudges and runs underneath pop flies.	

Coordination and Sports Score:_____

Driving

71	Has difficulty judging the position of other cars	
72	Follows too closely.	
73	Slow to respond.	
74	Poor at parallel parking.	
75	Has to be overly cautious.	
76	Becomes apprehensive if asked to drive at night	

Driving Section Score:_____

Attention

77	Attention is much better when using ears to listen than when using eyes to read.	
78	Attention is good for math (except for story problems) but poor for reading.	
79	Homework is a battle	

80	During reading and homework there comes a point after which it does no good to push any further. Your child "shuts down."	
81	The longer your child uses eyes for reading or writing, the greater the frustration and fidgeting become	
82	Assignments aren't completed in school and have to be brought home.	
83	Your child can't "stay on task" when reading or writing.	
84	Needs to put his/her hands on everything. Information from eyes alone isn't enough.	
85	Has to work to sit in a chair, seems to be constantly readjusting balance.	
86	Has the same reading struggles whether on or off medication.	
87	"Attention" problems develop when schoolwork or reading is mentioned. Attention is fine for "hands on" mechanical type activities.	

Attention Section Score:_____

Behavior, Self Esteem. Relationships

88	Your child feels unintelligent	
89	Self-confidence is low, attitude is poor	
90	Your child is either worn out or angry when coming home from school.	
91	Your child's poor eye contact makes others assume your child isn't listening.	
92	You child is unhappy or withdrawn.	
93	Your child has books rather than friends.	
94	In school your child is ridiculed by other students or the teacher.	
95	Your child's frustration in school seems to trigger behavior problems.	
96	Homework ends up with you angry and your child crying.	
97	In sports, your child is left sitting on the bench. Your child isn't asked to participate.	
98	Your child's struggle with schoolwork affects the whole family	
99	Your child's school performance could limit future educational and job opportunities.	
100	Grades are good but your child isn't working up to potential and the whole family feels the frustration.	

Behavior, Self Esteem, Relationships Section Score:_____

Scoring Your Child's Results:

Physical Complaints Section Score _____

Learning to Read Section Score _____

Reading to Learn Section Score _____

Getting it on Paper Section Score _____

Coordination and Sports Section Score _____

Driving Section Score _____

Attention Section Score _____

Behavior, Self Esteem, Relationships Section Score_____

Grand Total: _____

It is important for our Center to understand your child as a whole. Below, please give a brief description of your child as a person:

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____

When pursuing Neuro-Visual Training, what would be your academic and behavioral goals for your child?

_____

_____
_____
_____
_____
_____

What goals would your child like to achieve with Vision Therapy?

_____
_____
_____
_____

Please provide the contact for family doctor, pediatrician, teacher, speech pathologist)

Name:_____
Office:_____
Type of Practitioner:_____
Phone:_____
Fax:_____
Address:_____

Name:_____
Office:_____
Type of Practitioner:_____
Phone:_____
Fax:_____
Address:_____

Do you consent for the release of the report to other healthcare providers? Yes / No

PLEASE <u>EMAIL</u> (wardenoptometry@gmail.com) OR <u>FAX</u> (905-940-2015)

THE COMPLETED QUESTIONNAIRE BY_____